

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7304

07254

Reg. Dist. 9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Frostburg</u>				CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Jennings</u> <u>11X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Miners Hospital.</u>				STREET ADDRESS (If rural, give location) <u>✓</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Isaac</u>		(Middle) <u>Newton</u>		(Last) <u>Bittinger</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>April 19-1873</u>	
				9. AGE last birthday: <u>82</u> yrs.		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug, 14 19 55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Odd jobs</u>		11. BIRTHPLACE (State or foreign country): <u>Jennings, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Bittinger</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Speicker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>213-18-2561</u>		17. INFORMANT & ADDRESS: <u>(wife) Effie May Bittinger, Jennings, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
<p><u>812X</u></p> <p>Immediate cause (a) <u>Intracranial hemorrhage</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b) <u>Crushed skull.</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Hit by an auto.</u></p>				<p><u>sudden</u></p>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway #40 Near Grantsville Garrett Md.</u>		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug. 14-1955 P. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Walking on highway against traffic, hit by auto.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 15-1955</u>			
<u>H. V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
<u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAM. <u>Aug. 15-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>8-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Grantsville Cem.</u>	
DATE REC'D BY LOCAL REG. <u>8-17-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Roe</u>		24. FUNERAL DIRECTOR <u>Newman Funeral Home</u>	
				ADDRESS <u>Donald Newman Grantsville, Md.</u>	

BUREAU V. 2

AUG 22 1955

RECEIVED

7253

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07255

7253

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u> MARYLAND				STATE <u>W.VA.</u> COUNTY <u>Mineral</u>			
CITY OR TOWN <u>02 CUMBERLAND</u> (If outside corporate limits, write RURAL and give nearest town)				CITY OR TOWN <u>85X-3 SPRINGFIELD Road</u> (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60 MEMORIAL HOSPITAL MEMORIAL AVE.</u>				STREET ADDRESS (If rural give location) <u>Near Fort Ashby, W.Va.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LUCY Bell BLAMBLE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 19 1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG 19, 1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA Fort Ashby</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NICHOLAS BEAM, NICHOLAS</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL CEDERS SEEDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>MEMORIAL HOSPITAL, CUMBERLAND, MD,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arterio-sclerotic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular Disease</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-19-55</u> to <u>8-19-55</u> , that I last saw the deceased alive on <u>8-19-55</u> , and that death occurred at <u>9:53 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. D. Williams</u>				ADDRESS (Street, city, town, state) <u>Cumberland</u> DATE SIGNED <u>8-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Beam family cem.</u>		LOCATION (City, town, or county) (State) <u>Near Fort Ashby, W.Va</u>	
24. REC'D BY REGISTRAR <u>Aug 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

01255

DEPT. OF HEALTH

ALL DEATHS MUST BE REPORTED TO THE DEPARTMENT OF HEALTH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

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DATE OF DEATH

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BUREAU V. S.

AUG 24 1955

RECEIVED

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07256

7395 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carrol</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
22 TOWN <u>Frostburg, Md.</u>		2		TOWN <u>Mt. Airey, Maryland</u>		06 X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miners Hospital Frostburg, Maryland</u>				Box 76			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Linda</u> (Middle) <u>Ann</u> (Last) <u>Burdette</u>				Aug. 12		19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
female	white	child	June 18, 1949	6 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
child					Frederick, Maryland		U.S.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Kenneth Burdette				Evelyn Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
					Kenneth Burdette, Mt. Airey, Md.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
587.2 IMMEDIATE CAUSE (A)				<u>Pancreatic Fibrosis</u>		<u>Life</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Bilateral Bronchiectases</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 12</u> , 19 <u>55</u> , to <u>Aug 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 12</u> , 19 <u>55</u> , and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm C Lane</u>				ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>Aug 25 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8-15-1955		Pine Grove Cemetery		Mt. Airey, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 8-12-55		<u>Mrs. Eleanor A. Hines</u>		<u>C. M. Waltz, Jr.</u>		<u>Winfield, Md.</u>	
		<u>Mrs. Nancy N. Rice</u>					

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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Aug 15 1955

RECEIVED

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07257

7254 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>					
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)					
TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
<u>62 Sacred Heart Hospital</u>		<u>217 Knox St.</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Matthew</u>		(Middle) <u>Mark</u>		(Last) <u>Burley</u>		<u>8</u> <u>11</u> <u>19 55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/23/99</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refuse collection</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Burley</u>				14. MOTHER'S MAIDEN NAME <u>Laura Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 05 8457</u>		17. INFORMANT & ADDRESS <u>Patient's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 11, 19 55</u> to <u>Aug 11, 19 55</u> , that I last saw the deceased alive on <u>Aug 11, 19 55</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. T. Treaskis, Sr.</u>				ADDRESS (Street, city, town, state) <u>M.D. Cumberland, Md.</u>			
DATE SIGNED <u>Aug 12, 1958</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Kight, Cumberland, Md.</u>		ADDRESS	

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 10

AT THE RESIDENCE OF THE DECEASED

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

AUG 16 1955

RECEIVED

7255

CERTIFICATE OF DEATH

07258

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>Life</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>505 Eastern Avenue</u>				STREET ADDRESS (If rural give location) <u>505 Eastern Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>PAUL</u> (Middle) <u>LEVI</u> (Last) <u>BURLEY</u>				(Month) (Day) (Year) <u>Aug. 21, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct. 17, 1903</u>	<u>51</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Inspector</u>		<u>Construction</u>		<u>Hyndman, Pa.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Burley</u>				<u>Laura Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>214 05 7189</u>		<u>Edith Sara Burley, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>two hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>two years ?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 29</u> , 19 <u>53</u> , to <u>Aug. 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>August 20</u> , 19 <u>55</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>50 Pershing Street, Cumberland, Md.</u>		DATE SIGNED <u>8-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cem., Cumberland, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Aug. 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Light, Cumberland, Md.</u>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07259

7315

CERTIFICATE OF DEATH

Reg. Dist. No. 8

Item 8, Film G186 9-8-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany MARYLAND				STATE MD. COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town) Midland				CITY (If outside corporate limits, write RURAL and give nearest town) Midland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Paradise Street				STREET ADDRESS (If rural give location) Paradise Street			
3. NAME OF DECEASED (Type or Print) Rose Cunningham Byrne				4. DATE OF DEATH Aug, 22 19 55			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 1884 Oct, 6th, 1885	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday 70 yrs.		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.	
13. FATHER'S NAME John Cunningham				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) No (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME Mary Ann Murphy		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT & ADDRESS Mrs. Mary Dilfer, Midland, MD.				18. MEDICAL CERTIFICATION (DAUGHTER)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.0 IMMEDIATE CAUSE (A) Coronary Occlusion				5 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease				2 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Heart Failure				6 mos.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 8, 19 54 , to 8-22, 19 55 , that I last saw the deceased alive on 8-22, 19 55 , and that death occurred at 1:50 PM , from the causes and on the date stated above.							
SIGNATURE George Richards M.D.				ADDRESS (Street, city, town, state) Lonaconing DATE SIGNED 8/22/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF August, 24, 1955		NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		LOCATION (City, town, or county) (State) Fröstburg, MD.	
24. REC'D BY REGISTRAR 8-24-55		REGISTRAR'S SIGNATURE Janette M Bond		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, MD.			

RECEIVED

SEP 1 1955

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07260

7256

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland		LENGTH OF STAY (in this place) 2yrs. 2days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat				STREET ADDRESS (If rural give location) Braddock Road, R.F.D. #5			
3. NAME OF DECEASED (First) (Middle) (Last) Henry Arthur Clayton				4. DATE OF DEATH (Month) (Day) (Year) Aug. 23 1955			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH Oct. 22, 1875	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Upper Tract, Penelton Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Clayton				14. MOTHER'S MAIDEN NAME Margaret Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-07-0760		17. INFORMANT & ADDRESS Mrs. Henry A Clayton Braddock Road Cumberland, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary Sclerosis						79	
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocarditis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) General Arteriosclerosis						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis.						29yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 21, 1955 to Aug 22, 1955 , that I last saw the deceased alive on Aug 22, 1955 , and that death occurred at 10:40 AM , from the causes and on the date stated above.							
SIGNATURE James B. McLean, M.D.		ADDRESS (Street, city, town, state) 49 Greene St. Baltimore, Md.		DATE SIGNED 8-23-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/26/55		NAME OF CEMETERY OR CREMATORY Prosperity Cemetery		LOCATION (City, town, or county) (State) Flintstone, Md	
24. REC'D BY REGISTRAR Aug 24, 1955		REGISTRAR'S SIGNATURE Walter R. Frank, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.	

07280

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

Place of Birth

Place of Death

Cause of Death

Place of Death

Place of Death

Place of Death

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BUREAU V. S.

AUG 29 1955

RECEIVED

RECEIVED

7257

07261

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town) Dawson
 STREET ADDRESS R.F.D. #3 (If rural, give location) Box 124
Keyser, W. Va.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Alice May Ross Coleman

4. DATE OF DEATH

(Month)

(Day)

(Year)

Aug. 9 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

female whitemarried Oct. 10-190351 yrs.Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife10b. KIND OF BUSINESS OR INDUSTRY: Own Home11. BIRTHPLACE (State or foreign country): Lonaconing Md.12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

John E. Ross

14. MOTHER'S MAIDEN NAME:

Laura Shimer15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS:

(daughter) Mrs. Pearl Cook, Dawson, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause

(a)

Cerebral hemorrhage (apoplexy)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

Arteriosclerosis with hypertention.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 hr.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Deming M.D.N. V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED

Aug. 9-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug. 10, 1955Walter R. Thant, M.D.E. S. Boal, Westernport, Md.Boal

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 12 1955

BUREAU V. S.

07262

7258 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <u>Cumberland</u>		20 years		TOWN <u>Cumberland</u>		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
01 534 Fairview, Ave.				534 Fairview, Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Crowe</u> (Last)				(Month) <u>Aug.</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Widowed	June 28, 1868	87 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housekeeper at Home					Frostburg, Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Offman</u>				<u>Catherine Lemmert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		none		<u>Ovelia Walker. 534 Fairview, Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cerebral Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Advanced Age.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19, 1955</u> , to <u>Aug. 2, 1955</u> , that I last saw the deceased alive on <u>Aug 2, 1955</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. Lee Silcox, M.D.</u>				ADDRESS (Street, city, town, state) <u>1330 Ave. Cumberland, Md.</u>		DATE SIGNED <u>Aug 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8/5/55		St. Lukes Cemetery		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 4, 1955</u>		<u>Walter R. Frank, M.D.</u>		<u>H. Lee Silcox</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Admission Fee
The amount of the
Admission Fee

BUREAU V
6 1955

RECEIVED

7259 **CERTIFICATE OF DEATH**

07263

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		7/7/50		TOWN Frostburg		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Thomas J. Crump				August 5, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	4/24/1885	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired - Trackman on C. & P.			Maryland		U. S. A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Milton H. Crump				Kathryn Rhoder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				Chronic Hypertension			
ANTECEDENT CAUSE(S) DUE TO				Cerebral arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Chronic Gastro-Enteritis			
XX OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Senile Deterioration			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 2, 1932, to Aug 4, 1955, that I last saw the deceased alive on Aug 4, 1955, and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
James E. McLean, M.D.				49 Locust St. 8-5-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8-7-1955		F'bg. Memorial Park		Frostburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug 7, 1955		Walter R. Frantz, M.D.		J. R. Durst,		Frostburg, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

43263

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

JUN 9 1955

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
RECEIVED
JUN 9 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland
 TOWN Cumberland
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 533 Ford Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town) Cumberland
 TOWN Cumberland
 STREET ADDRESS (If rural, give location) 533 Ford Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HowardSamuelDeetz

4. DATE OF DEATH

(Month)

(Day)

(Year)

August 119 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

malewhitewidowerSept. 6-187876611955

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Howard DeetzAnna Sellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

no705-00-9867(daughter) Mrs. Pansie Shrout, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

241X
Immediate causeCoronary occlusionDUE TO Cardio-vascular-renal disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause lastDUE TODUE TO(c) Bronchial asthma with emphysema

INTERVAL BETWEEN ONSET AND DEATH

sudden3 yrs.3 yrs.severalyears.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc. INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER ☐
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☒

Aug. 1-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug. 2, 1955Walter R. Brant, M.D.William H. Light, ""

MARGIN RESERVED FOR BINDING

BUREAU Y. S.

AUG 4 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>Bedford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
<u>122 TOWN Cumberland</u>		<u>30 Minutes</u>		<u>Rural) Hyndman 75 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. # 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Ray Junior DeVore</u>				<u>Aug. 24 19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>June 20-1953</u>	
9. AGE last birthday: <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harvey DeVore</u>				14. MOTHER'S MAIDEN NAME: <u>Thelma Bolt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Route #1 (father) Harvey DeVore, Hyndman, Pa.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ORAL AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						5 hours.	
<u>527.2</u> Immediate cause (a) <u>Intestinal perforation</u> DUE TO Antecedent cause(s) (b) <u>Ascaris lumbricoides</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Pulmonary edema & congestion (marked)</u>						?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 24-1955</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>8-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parter Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 25, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		24. FUNERAL DIRECTOR <u>Harvey H. Ziegler, Hyndman</u>		ADDRESS <u>Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>1 DAY</u>		TOWN <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>134 ELDER Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>HENRY J DRESSMAN</u>				<u>AUGUST 1 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>MARCH 29, 1890</u>	<u>65</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Machinist's Helper</u>		<u>B. & O. R. R. Co.</u>		<u>MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>DRESSMAN, JOHN J.</u>				<u>MEICH, MARY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unit)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>W. W. I</u>		<u>705-05-4540</u>		<u>MEMORIAL HOSPITAL</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>587.0 IMMEDIATE CAUSE (A) <u>Acute Hemorrhagic Pancreatitis</u></u>				<u>12 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Shock + Myocard. Collapse</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/13/55</u>, 19<u>55</u>, to <u>8/1/55</u>, 19<u>55</u>, that I last saw the deceased alive on <u>8/1/55</u>, 19<u>55</u>, and that death occurred at <u>1:10A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James F. Scarpelli</u>				DATE SIGNED <u>8/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 4, 1955</u>		<u>Sts. Peter & Paul Cem.</u>		<u>Cumberland, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>Aug. 3, 1955</u>		<u>Winter R. Frantz, M.A.</u>		<u>James F. Scarpelli, Cumberland, Maryland.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1 With in corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07267

7263 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		STATE WEST VIRGINIA		COUNTY HARDY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 03 CUMBERLAND		LENGTH OF STAY (In this place) 3 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD		85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVENUE		STREET ADDRESS (If rural give location) ✓					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) 03 BABY		(Middle) BOY		(Last) EARLE		6, 19 55	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH AUGUST 3, 1955		9. AGE last birthday yrs. 3		IF UNDER 1 YEAR Months 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JESSE JAMES EARLE				14. MOTHER'S MAIDEN NAME TAVA MARIE ROSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
776X IMMEDIATE CAUSE (A) prematurity 26 weeks						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 30 Aug, 1955 to 6 Aug, 1955, that I last saw the deceased alive on 6 Aug, 1955, and that death occurred at 6:27 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Jules B. Nuttall</i>		DATE THEREOF August 8, 1955		NAME OF CEMETERY OR CREMATORY Olivet Cemetery		LOCATION (City, town, or county) Moorefield, West Virginia.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR Aug 7, 1955		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter R. Frantz, M.D.</i>		ADDRESS P. E. Thrush, Moorefield, West Virginia.	

2085334312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		MARYLAND	STATE	Md.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Cumberland		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Dead on arrival at the Memorial Hospital.		STREET ADDRESS	(If rural, give location) 226 Pear St.	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	William	Isaac	Ensminger	Aug.	5 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
male	white	Married	Jan. 2-1887	68 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Stationary Engineer	Queen City Brew.		Williamsport, Md.		U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Samuel Ensminger			Catherine Dodd		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no		214-05-4972		(son) Walter Ensminger, Cumberland, Md.	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause		(a)	Coronary occlusion		sudden
Antecedent cause(s)		(b)	Coronary sclerosis		?
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)	Myocardial infarction (old)		about 12 yrs.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		Aug. 5-1955	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		8-8-55		Rose Hill Cem.	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
Hagerstown, Md.		Charles L. George		Cumberland, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			
Aug. 7, 1955		Walter R. Traub, M.D.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 9 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7306

CERTIFICATE OF DEATH

07269

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>1 day</u>		TOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Miners Hospital</u>				<u>/</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ROY JOSEPH FELKER</u>				<u>Aug. 10, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Min.
<u>male</u>	<u>white</u>	<u>single</u>	<u>Aug. 9, 1955</u>		<u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>infant</u>					<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Felker</u>				<u>Jean Wilhelm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Robert Felker, Eckhart, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>762.5 atelectasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coarctation</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Marginal Placenta Praevia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-9</u> , 19 <u>55</u> , to <u>8-10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-10</u> , 19 <u>55</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H.O. Diehl</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>8/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-10-1955</u>		<u>Eckhart Cemetery</u>		<u>Eckhart, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8-10-1955</u>		<u>Mr. Elmer D. Thomas</u>		<u>J. R. Durst,</u>		<u>Frostburg, Md.</u>	

2085211382

Mrs. Nancy A. Roe W

03280

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Form 10-1-55

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. SEX

11. RACE

12. RELIGION

13. MARRIAGE

14. EDUCATION

15. SERVICE

16. CITIZENSHIP

17. MANNER OF DEATH

18. PLACE OF DEATH

19. SEX

20. RACE

21. RELIGION

22. MARRIAGE

23. EDUCATION

24. SERVICE

25. CITIZENSHIP

26. MANNER OF DEATH

27. PLACE OF DEATH

28. SEX

29. RACE

30. RELIGION

31. MARRIAGE

32. EDUCATION

33. SERVICE

34. CITIZENSHIP

35. MANNER OF DEATH

36. PLACE OF DEATH

37. SEX

38. RACE

39. RELIGION

40. MARRIAGE

41. EDUCATION

42. SERVICE

43. CITIZENSHIP

44. MANNER OF DEATH

45. PLACE OF DEATH

46. SEX

47. RACE

48. RELIGION

49. MARRIAGE

50. EDUCATION

51. SERVICE

52. CITIZENSHIP

BUREAU V. 1

AUG 15 1955

RECEIVED

RECEIVED

1. **Within corporate limits**

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07270

7265

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62</u> <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>422 Baltimore Ave.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u> (Middle) <u>Elizabeth</u> (Last) <u>Fisher</u>				(Month) <u>8</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/29/1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lemuel Spicer</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-9028</u>		17. INFORMANT & ADDRESS <u>Patient's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>443x</u> IMMEDIATE CAUSE (A) <u>massive cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 da</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension, severe</u>				<u>37 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive heart disease</u>				<u>37 yr.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 11, 1955</u> to <u>8-11-1955</u> , that I last saw the deceased alive on <u>Aug. 11, 1955</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. R. Hallinan M.D.</u>				ADDRESS (Street, city, town, state) <u>140 Bedford St. Cumberland, Md.</u>		DATE SIGNED <u>8/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>S.S. Peter & Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Aug. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 TOM

00328

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

BUREAU A. B.

AUG 15 1955

RECEIVED

NOV 19 1955

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NOV 19 1955
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07271

7266 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		20 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,				717 BEDFORD STREET			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
FLOYD L. FISHER				AUGUST 15 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
MALE	WHITE	Widowed	FEB. 13 1886	69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired clerk		B.&O. Freight Office		W. Va.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SANFORD S. FISHER				FLORENCE MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO				Marian Fisher, Washington, D. C.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
539.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
Terminal pneumonia						2 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
Starvation							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 8:40 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Charles L. George</i>				<i>Cumberland, Md.</i>		<i>8/15/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Aug. 17, 1955		Rose Hill Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Aug. 17, 1955</i>		<i>Walter R. Panty, M.D.</i>		<i>Charles L. George,</i>		<i>Cumberland, Md.</i>	

03371

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

EDUCATION

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

BUREAU V. S.

AUG 18 1955

RECEIVED

7267 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		9 DAYS		TOWN FROSTBURG		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL MEMORIAL AVENUE		STREET ADDRESS (If rural give location)		RT.#1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
HENRY T FRAME				8 13 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	MARCH 12, 1869	86	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED BLACK SMITH - W. M. Bay.		W. VA.		W. VA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES FRAME				RACHEL BARNETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		705-10-6101		MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A)				Cerebral Vascular			
ANTECEDENT CAUSE(S) DUE TO				Disease of disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8:40, 1955, to 2:13, 1955, that I last saw the deceased alive on 8:12, 1955, and that death occurred at 7:35A.M. from the causes and on the date stated above.							
SIGNATURE W. J. Williams				ADDRESS (Street, city, town, state) M.D. Cumberland		DATE SIGNED 8-13-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 15, 1955		Hillcrest Burial Park		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 15, 1955		Winter R. Frantz, M.D.		Durst Funeral Home, Frostburg, Maryland.			

07578

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Form 100-1

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF DEATH

6. TIME OF DEATH

7. DAY OF DEATH

8. MONTH OF DEATH

9. NAME OF HOSPITAL

10. CITY

11. COUNTY

12. STATE

13. DATE OF BIRTH

14. TIME OF BIRTH

15. PLACE OF BIRTH

16. SEX

17. RACE

18. NAME OF PHYSICIAN

19. NAME OF HOSPITAL

20. NAME OF DECEASED

21. NAME OF DECEASED

22. NAME OF DECEASED

23. NAME OF DECEASED

24. NAME OF DECEASED

25. NAME OF DECEASED

26. NAME OF DECEASED

27. NAME OF DECEASED

28. NAME OF DECEASED

29. NAME OF DECEASED

30. NAME OF DECEASED

BUREAU V. 2

AUG 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07273

7316 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		STATE <u>Maryland</u> COUNTY <u>Allegheny</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>1 mi east-McCoole</u>		LENGTH OF STAY (in this place) <u>50 yrs</u>		OR TOWN <u>1 Mi East McCoole</u>		OR TOWN <u>1 Mi East McCoole</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21st Lane</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21st Lane</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John Joseph Gordon</u>				<u>Aug 29 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 4, 1894</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Flintstone, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ullysses G. Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Bessie M. Crabtree</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Harvey L. Gordon, as above</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
199.1 IMMEDIATE CAUSE (A) <u>spindle cell sarcoma left thigh</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7-1954</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>with metastases to lung -</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> <u>19 54</u> , to <u>Aug 29</u> , <u>19 55</u> , that I last saw the deceased alive on <u>Aug 29</u> , <u>19 55</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M. D. <u>[Signature]</u> DATE SIGNED <u>8-30-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 31, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Waxler Cemetery</u>		LOCATION (City, town, or county) (State) <u>Danville, Allegheny, Md.</u>	
24. REC'D BY REGISTRAR <u>8-31-55</u>		REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Breal</u>		ADDRESS <u>Westernport, Maryland</u>	

I hereby certify that the person named in the above certificate is dead and that the death occurred at the place and on the date stated above.
 I am a duly qualified medical practitioner and I am not aware of any other person who has been in contact with the deceased person within the last seven days.
 I am not aware of any other person who has been in contact with the deceased person within the last seven days.
 I am not aware of any other person who has been in contact with the deceased person within the last seven days.

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

07573

1. NAME OF DECEASED JOHN J. SMITH		2. PLACE OF BIRTH BALTIMORE, MARYLAND	
3. SEX MALE		4. RACE WHITE	
5. DATE OF BIRTH JAN 15 1890		6. DATE OF DEATH SEP 10 1955	
7. TIME OF DEATH 10:30 AM		8. PLACE OF DEATH HOME	
9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. SIGNATURE OF PHYSICIAN J. H. SMITH		12. SIGNATURE OF WITNESSES J. H. SMITH	
13. SIGNATURE OF DECEASED JOHN J. SMITH		14. SIGNATURE OF NEXT OF KIN J. H. SMITH	
15. SIGNATURE OF BURIAL OFFICER J. H. SMITH		16. SIGNATURE OF CLERK J. H. SMITH	
17. SIGNATURE OF REGISTRAR J. H. SMITH		18. SIGNATURE OF CLERK J. H. SMITH	
19. SIGNATURE OF CLERK J. H. SMITH		20. SIGNATURE OF CLERK J. H. SMITH	
21. SIGNATURE OF CLERK J. H. SMITH		22. SIGNATURE OF CLERK J. H. SMITH	
23. SIGNATURE OF CLERK J. H. SMITH		24. SIGNATURE OF CLERK J. H. SMITH	
25. SIGNATURE OF CLERK J. H. SMITH		26. SIGNATURE OF CLERK J. H. SMITH	
27. SIGNATURE OF CLERK J. H. SMITH		28. SIGNATURE OF CLERK J. H. SMITH	
29. SIGNATURE OF CLERK J. H. SMITH		30. SIGNATURE OF CLERK J. H. SMITH	
31. SIGNATURE OF CLERK J. H. SMITH		32. SIGNATURE OF CLERK J. H. SMITH	
33. SIGNATURE OF CLERK J. H. SMITH		34. SIGNATURE OF CLERK J. H. SMITH	
35. SIGNATURE OF CLERK J. H. SMITH		36. SIGNATURE OF CLERK J. H. SMITH	
37. SIGNATURE OF CLERK J. H. SMITH		38. SIGNATURE OF CLERK J. H. SMITH	
39. SIGNATURE OF CLERK J. H. SMITH		40. SIGNATURE OF CLERK J. H. SMITH	
41. SIGNATURE OF CLERK J. H. SMITH		42. SIGNATURE OF CLERK J. H. SMITH	
43. SIGNATURE OF CLERK J. H. SMITH		44. SIGNATURE OF CLERK J. H. SMITH	
45. SIGNATURE OF CLERK J. H. SMITH		46. SIGNATURE OF CLERK J. H. SMITH	
47. SIGNATURE OF CLERK J. H. SMITH		48. SIGNATURE OF CLERK J. H. SMITH	
49. SIGNATURE OF CLERK J. H. SMITH		50. SIGNATURE OF CLERK J. H. SMITH	
51. SIGNATURE OF CLERK J. H. SMITH		52. SIGNATURE OF CLERK J. H. SMITH	
53. SIGNATURE OF CLERK J. H. SMITH		54. SIGNATURE OF CLERK J. H. SMITH	
55. SIGNATURE OF CLERK J. H. SMITH		56. SIGNATURE OF CLERK J. H. SMITH	
57. SIGNATURE OF CLERK J. H. SMITH		58. SIGNATURE OF CLERK J. H. SMITH	
59. SIGNATURE OF CLERK J. H. SMITH		60. SIGNATURE OF CLERK J. H. SMITH	
61. SIGNATURE OF CLERK J. H. SMITH		62. SIGNATURE OF CLERK J. H. SMITH	
63. SIGNATURE OF CLERK J. H. SMITH		64. SIGNATURE OF CLERK J. H. SMITH	
65. SIGNATURE OF CLERK J. H. SMITH		66. SIGNATURE OF CLERK J. H. SMITH	
67. SIGNATURE OF CLERK J. H. SMITH		68. SIGNATURE OF CLERK J. H. SMITH	
69. SIGNATURE OF CLERK J. H. SMITH		70. SIGNATURE OF CLERK J. H. SMITH	
71. SIGNATURE OF CLERK J. H. SMITH		72. SIGNATURE OF CLERK J. H. SMITH	
73. SIGNATURE OF CLERK J. H. SMITH		74. SIGNATURE OF CLERK J. H. SMITH	
75. SIGNATURE OF CLERK J. H. SMITH		76. SIGNATURE OF CLERK J. H. SMITH	
77. SIGNATURE OF CLERK J. H. SMITH		78. SIGNATURE OF CLERK J. H. SMITH	
79. SIGNATURE OF CLERK J. H. SMITH		80. SIGNATURE OF CLERK J. H. SMITH	
81. SIGNATURE OF CLERK J. H. SMITH		82. SIGNATURE OF CLERK J. H. SMITH	
83. SIGNATURE OF CLERK J. H. SMITH		84. SIGNATURE OF CLERK J. H. SMITH	
85. SIGNATURE OF CLERK J. H. SMITH		86. SIGNATURE OF CLERK J. H. SMITH	
87. SIGNATURE OF CLERK J. H. SMITH		88. SIGNATURE OF CLERK J. H. SMITH	
89. SIGNATURE OF CLERK J. H. SMITH		90. SIGNATURE OF CLERK J. H. SMITH	
91. SIGNATURE OF CLERK J. H. SMITH		92. SIGNATURE OF CLERK J. H. SMITH	
93. SIGNATURE OF CLERK J. H. SMITH		94. SIGNATURE OF CLERK J. H. SMITH	
95. SIGNATURE OF CLERK J. H. SMITH		96. SIGNATURE OF CLERK J. H. SMITH	
97. SIGNATURE OF CLERK J. H. SMITH		98. SIGNATURE OF CLERK J. H. SMITH	
99. SIGNATURE OF CLERK J. H. SMITH		100. SIGNATURE OF CLERK J. H. SMITH	

BUREAU V. B.
 SEP 6 1955
 RECEIVED

Outside of
City Limits

7317

07274

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural near-Corrigansville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at George Funeral Home.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. #1 Cash Valley</u>			
3. NAME OF DECEASED: (First) <u>Joseph</u>		(Middle) <u>Graham</u>		(Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 22 19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 16-1907</u>		9. AGE last birthday: <u>48</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Stationary Engineer-C.C. & Supply Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Johnson Graham</u>				14. MOTHER'S MAIDEN NAME: <u>Alice Hergett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>220-10-2338</u>		17. INFORMANT & ADDRESS: <u>Cumberland, Md. Vera C. Mauk Graham R.F.D. #1</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						sudden	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Artheromatus sclerosis.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>H.V. Deming M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 22/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>8/25/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Zion Memorial Cem.</u>		LOCATION (City, town, or county) (State): <u>Cumberland, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 23, 1955</u>		REGISTRAR'S SIGNATURE: <u>Winter R. Frantz, M.D.</u>		24. FUNERAL DIRECTOR: <u>H. Wayne George</u>		ADDRESS: <u>Cumberland, Md.</u>	

BUREAU V. S.

AUG 25 1955

RECEIVED

7268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		15 DAYS		TOWN FROSTBURG			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL MEMORIAL AVE.				44 MECHANIC ST.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MR. CARL (Middle) E (Last) GRIFFITHS				(Month) AUG 30 (Day) 19 (Year) 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	SINGLE	JAN 1, 1929	26 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Fortisan Dept.		Celanese Corp.		WEST VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
THOMAS GRIFFITHS				PEARL CROWE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		213-24-6814		MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
527.0 IMMEDIATE CAUSE (A) Atelectasis, bilateral, post-operative							
ANTECEDENT CAUSE(S) DUE TO (B) operative							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
8/30/55		Hypertrophic Gastric Mucosa				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/15 , 19 55 , to 8/30 , 19 55 , that I last saw the deceased alive on 8/29 , 19 55 , and that death occurred at 8:30AM , from the causes and on the date stated above.							
SIGNATURE Geo. H. Gray, Jr.				DATE SIGNED 8/30/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-2-1955		Mt. Zion Cemetery		Garrett County, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 1, 1955		Walter R. Frank, M.D.		Joseph R. Durst		Frostburg, Md.	

INSTRUCTIONS

1 **WITHIN 24 HOURS AFTER DEATH.** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

07325

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

ALLEN, ALBERT

ALLEN, ALBERT

ALLEN, ALBERT

2. AGE

3. SEX

4. PLACE OF BIRTH

5. PLACE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

BUREAU V. 2

SEP 2 1955

RECEIVED

RECEIVED
SEP 2 1955
BUREAU V. 2

7269

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN Cumberland, Md		Lifetime		TOWN Cumberland, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
808 Sylvan Ave				808 Sylvan Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
Elizebeth L. Grimm				8-4-55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Widowed	Sept 15, 1874	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Cumberland, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Lavin				Kathryn Kirby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Anite Hardy 808 Sylvan Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				Myocardial Infarct			
ANTECEDENT CAUSE(S) DUE TO				Coronary atherosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				Generalized atherosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				Generalized Rheumatoid Arthritis			
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
None		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3 mo	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
None		None		None		None	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
None		None		None			
22. I hereby certify that I attended the deceased from Aug 1, 1955 to Aug 4, 1955 , that I last saw the deceased alive on Aug 4, 1955 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.							
SIGNATURE J. Haeenan MD				ADDRESS (Street, city, town, state) 140 Bedford St Cumberland, Md			
DATE SIGNED 8-5-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8-6-55		St. Patrick Cem.		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug 5, 1955		Winter R. Pantz, M.D.		James F. Scarpelli		Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

0-578

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Reg. No. 11

NAME OF DECEASED (Print or Type)

John J. ...
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DATE OF DEATH
 ...

PLACE OF DEATH
 ...

CAUSE OF DEATH (Print or Type)

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1. The death of a person is a public event and the fact of death should be ascertained and recorded as soon as possible after the death has occurred. The death should be recorded on this certificate as soon as the facts are known. The certificate should be filled out by the attending physician or the coroner, or the health officer of the local health department, or the registrar of the vital statistics office. The certificate should be filed in the office of the registrar of the vital statistics office. The certificate should be made available to the public upon request.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07277

7270

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>9 DAYS</u>		TOWN <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>MEMORIAL HOSPITAL</u>				<u>519 LOUISIANA AVE.</u>			
<u>MEMORIAL AVE.</u>							
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>MR. OSCAR</u>		(Middle) <u>C.</u>		(Last) <u>GURLEY</u>		(Month) <u>AUG. 31</u>	
(Type or Print)						(Day) <u>19 55</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>MALE</u>		<u>WHITE</u>		<u>MARRIES</u>		<u>APRIL 30, 1886</u>	
						<u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Auto Dealer</u>		<u>Own Business</u>		<u>MARYLAND</u>		<u>Union Grove</u>	
						<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>LYCURGUS GURLEY</u>				<u>Roseann Belle Frantz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>MEMORIAL HOSPITAL, CUMBERLAND, MD,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>3 ± months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(B)	
						<u>Cerebral vascular arteriosclerosis?</u>	
						(C)	
						<u>arterial Hypertension</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>22 Aug</u>, 19<u>55</u>, to <u>31 Aug</u>, 19<u>55</u>, that I last saw the deceased alive on <u>31 Aug</u>, 19<u>55</u>, and that death occurred at <u>8:00AM</u> M., from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>W. A. V. O. Ome</u>		<u>Sept. 2, 1955</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		REGISTRAR'S SIGNATURE		<u>John J. Hafer,</u>		<u>Cumberland, Maryland</u>	
		<u>Sept. 2, 1955</u>					

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MAY 10 1955
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20540

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Page 1 of 2

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1955

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7271 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>1 mo. 23 days</u>		TOWN <u>Westernport</u>		<u>43</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sylvan Retreat</u>				<u>272 Main Street Ext.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>R</u> (Last) <u>Jones</u>				(Month) <u>Aug.</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>M</u>	<u>Sept. 1, 1876</u>	<u>78</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Crossing Watchman - Ret'd B. & O. R. R. Co.</u>				<u>Sir John Run, W. Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Thomas Jones</u>				<u>Margaret Weisenburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>705-05-9339</u>		<u>Mrs. John Jones</u> <u>272 Main St. Ext.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422.2</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic myocarditis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>Cerebral arteriosclerosis</u>			
(C)				<u>Chronic osteitis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Senile psychosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 2, 1955</u> to <u>Aug. 24, 1955</u> , that I last saw the deceased alive on <u>Aug. 24, 1955</u> , and that death occurred at <u>3a.</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>James E. McLean, M.D.</u>				<u>49 Greene St.</u>		<u>8-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 28, 1955</u>		<u>Philos Cemetery</u>		<u>Westernport, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug. 26, 1955</u>		<u>Walter R. Frank, M.D.</u>		<u>E. S. Boal, Westernport, Maryland.</u>			

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

03328

CERTIFICATE OF DEATH

Form No. 10

DATE OF DEATH

NAME OF DECEASED

RESIDENCE

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland
 TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) 514 Ridgewood Ave. Cumberland
 TOWN

STREET ADDRESS (If rural, give location) 514 Ridgewood Ave.
02

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CharlesKeech Jr.

4. DATE OF DEATH

(Month)

(Day)

(Year)

Aug 3119 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

malewhitesingleJan. 15-194411

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

StudentSt. Mary's SchoolCumberland, Md.U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Charles Anthony Keech, Sr.Vivian Decker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

nonone(mother) Vivian Decker Keech, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

DUE TO

Intracranial hemorrhage due to a fractured skull-sudden

Antecedent cause(s)

DUE TO

and fractured 3rd. Cervical vertebrae.

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

an auto accident.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway 51

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Aug. 31/55 P.M.21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

near Old Town Allegany Md.22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐ , Inspection ☐ , Inquiry ☒ , and find that death resulted from: Natural causes ☐ , Accident ☒ , Suicide ☐ , Homicide ☐ , Undetermined cause ☐ .

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D.

ASSISTANT MEDICAL EXAM.

Sept. 1/55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Sept. 2, 1955Walter L. Frantz, M.D.James T. Scarfelli"Scarfelli

MARGIN RESERVED FOR BINDING

RECEIVED

SEP 8 1965

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN <u>Cumberland</u>		<u>37 yrs</u>	TOWN <u>Cumberland</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
<u>Memorial Hospital</u>			<u>514 Ridgewood Ave.</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) (Middle) (Last)			(Month) (Day) (Year)		
<u>Charles Anthony Keech, Sr.</u>			<u>Aug. 31 19 55</u>		
(Type or Print)					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>Married</u>	<u>June 6-1918</u>	<u>37</u> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Manager of the Keech Pharmacy.</u>		<u>Cumberland, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>James E. Keech</u>			<u>Mary Agnes O'Neal</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
<u>Yes</u> <u>W.W.2</u>			<u>219-03-8296</u>		
17. INFORMANT & ADDRESS:					
<u>(wife) Vivian Keech, Cumberland, Md.</u>					

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>8/6x</u> Immediate cause (a) <u>Intrathoracic hemorrhage due to a crushed</u> DUE TO chest also Intra-abdominal hemorrhage due Antecedent cause(s) (b) <u>to a torn liver.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Automobile accident.</u>				<u>1 hr.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
<u>7-55</u>		<u>near-Old Town</u>		<u>Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<u>Aug. 31-1955 P.M.</u>		<u>While at work</u>		<u>Near head on collision, other car turned in front of Keech</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE					
<u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Sept 1-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Sept. 5, 1955</u>		<u>St. Mary's Cemetery</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Sept. 2, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>James F. Scarpelli</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 8 1955

RECEIVED

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Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07281

7274 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegheny</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>50 Yrs.</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>529 Beall Street</u>				STREET ADDRESS (If rural give location) <u>529 Beall Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>NETTIE</u> (Middle) <u>MARGARET</u> (Last) <u>KEEFER</u>				<u>August 5</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 11, 1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>own home</u>		<u>Thompson Twp., Pa.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Peter Calvin Peck</u>				<u>Sarah Sevalt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u> (If Yes, give war or dates of service)		<u>None</u>		<u>Mrs. Woodrow Bennett, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebro-Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>53</u> , to <u>Aug 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>55</u> , and that death occurred at <u>11:15</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>Joseph M. Brown</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md</u>		DATE SIGNED <u>8/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>August 8, '55</u>		<u>Rehobeth Meth. Cem.</u>		<u>Thompson Twp., Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 8, 1955</u>		<u>Walter R. Trautz, M.D.</u>		<u>John J. Hafer, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

AUG 9 1985

RECEIVED

07282

7275 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		6 1/2 HRS.		TOWN CUMBERLAND, Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL MEMORIAL AVE.		STREET ADDRESS		RT. #1, CASH VALLEY ROAD	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
NELLIE F. KEIDEL				AUGUST 22, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOW	SEPTEMBER 23, 1898	56 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Practical nurse		Krump Nursing		PENNA. Somerset County		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN FRESH				MARGARET HEDRICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		213-12-9035		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				Art. Scler. Cardio Vascular D.			
ANTECEDENT CAUSE(S) DUE TO				with myocardial failure -			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/20/55, 19....., to 8/22/55, 19....., that I last saw the deceased alive on 8/22/55, 19....., and that death occurred at 5:25 PM, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
B. Williams				8/22/55			
M.D. Cumberland				ADDRESS (Street, city, town, state)			
13. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 25, '55		Mt. Lebanon Cemetery		Somerset Co. Pennsylvania	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 25, 1955		Walter R. Frantz, M.D.		John J. Hafer, Cumberland, Md.			

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

07225

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

2075 CERTIFICATE OF DEATH

For Use by

LOCAL HEALTH OFFICER OR REGISTRAR

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 2

AUG 29 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		MARYLAND	STATE	Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL OR and give nearest town)	TOWN Cumberland		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
108 W. Third St.			108 W. Third St.		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
Clara (First) Virginia (Middle) Kenney (Last)			Aug. 26 19 55		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:		9. AGE last birthday:
Female	white	Widow	June 3-1885		70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):
Housewife			Own Home		Springfield, W. Va.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
J. William Taylor			Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:
no			none		(son) John W. Kenney, Cumberland, Md.

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
241X Immediate cause (a) Myocardial failure		sudden
DUE TO		
Antecedent cause(s) (b) Chronic myocarditis		8 yrs.
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c) Bronchial asthma		10 yrs.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
H. V. Deming M.D.		H. V. Deming M.D.		* Aug. 26-1955	
23. BURIAL, CREMATION, REMOVAL (Specify):		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Fond 9 Glenn Cem.		Greenspring W. Va.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Aug 27, 1955		Charles R. Frantz, M.D.		Louis Stein Inc. Cumb. Md.	

MARGIN-RESERVED FOR BINDING

RECEIVED
AUG 30 1955
BUREAU V. S.

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7277 CERTIFICATE OF DEATH

07284

DR. WHITWORTH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		STATE PENNSYLVANIA		COUNTY Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		4 DAYS		TOWN WELLERSBURG		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
BABY BOY KENNEY (James Patrick)				AUGUST 2 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
MALE	WHITE	SINGLE	JULY 29, 1955		4		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				CUMBERLAND, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CLYDE E. KENNEY				SHIRLEY A. BRODE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		Infant		MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
776X IMMEDIATE CAUSE (A)				Prematurity			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 29 July, 19 55, to 2 Aug, 19 55, that I last saw the deceased alive on 2 Aug, 19 55, and that death occurred at 8:27 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial				8/4/55		Sts. Peter & Paul Cem. Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 8, 1955		Walter R. Frantz, M.D.		John J. Hafer, Cumberland, Maryland			

2075293332

7278

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>D. C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Cumberland</u>		<u>1 day</u>		TOWN <u>Washington</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>301 D st., N. W.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louis</u> (Middle) <u>Kline</u> (Last)				(Month) <u>Aug.</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Single</u>	<u>?</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Photographs</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>501 Snyder, 225 Indiana Ave. N. W. Washington, D. C.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>3 hours</u>			
IMMEDIATE CAUSE (A) <u>Acute Left Ventricular Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial disease and</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Artery Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/20</u> , 19 <u>55</u> , to <u>8/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/20/55</u> , 19 <u>55</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>John J. Hafer</u> M.D.				ADDRESS (Street, city, town, state) <u>50 Pershing St. Cumberland</u>		DATE SIGNED <u>8/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>El Savatgrad Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR <u>Aug. 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1932

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Reg. No. 110

NAME OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF REINTERMENT

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland
 TOWN Cumberland

HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Sacred Heart Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town) Rural
 TOWN Rural

STREET ADDRESS Route # 6
 (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ClydeSpencerKuhns

4. DATE OF DEATH

(Month)

(Day)

(Year)

Aug. 2419 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

malewhitemarriedDec. 31-189361

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Contract PainterHouse PaintingMcKeesport, Pa.U.S.A.

13. FATHER'S NAME:

Spencer Kuhns

14. MOTHER'S MAIDEN NAME:

Theodosia Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Locust Grove, Md.
(wife) Bernadette Martin Kuhns, Rt. #6

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

Coronary occlusion

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
 giving rise to the above cause
 stating underlying cause last

(b).....

Coronary sclerosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

sudden

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Aug. 24-1955
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug. 25, 1955Winters R. Frantz, M.D.Wayne George"

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 29 1955

BUREAU V. F.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS-AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7307 CERTIFICATE OF DEATH

07287

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>				TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 First Street</u>				STREET ADDRESS (If rural give location) <u>210 First Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>GLADYS</u>		(Middle) <u>C.</u>		(Last) <u>KURTZ</u>		<u>Aug. 3, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>married</u>	<u>June 8, 1917</u>	<u>38</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Seamstress</u>		<u>Flushing Shirt Mfg.</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>John W. Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>220-16-6900</u>		17. INFORMANT & ADDRESS <u>Roy Kurtz, Frostburg, Md.</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
174X IMMEDIATE CAUSE (A) <u>ADVANCED CARCINOMA OF UTERUS</u>						<u>2 YRS.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8/3</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input checked="" type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/10</u> , 19 <u>55</u> , to <u>8/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/3</u> , 19 <u>55</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Martina M. H. Roe</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 Broadway - Frostburg, Md. 8/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-6-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Johnson Cemetery</u>		LOCATION (City, town or county) (State) <u>Garrett County Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Martina M. H. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	
DATE <u>8-5-55</u>							

[illegible]

2-2-2

BUREAU V. S.

AUG 8 1955

RECEIVED

2-2-22 Jan. 1904 H. 100

7280 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN Cumberland		LENGTH OF STAY (in this place) 7/15/55		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gilmore, Frostburg, Rt. #1 X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary				STREET ADDRESS (If rural give location) Rt. #1, Frostburg, Md.			
3. NAME OF DECEASED (First) (Middle) (Last) Howard F. Langley				4. DATE OF DEATH (Month) (Day) (Year) August 6, 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH 7/1/1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Mining			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Langley				14. MOTHER'S MAIDEN NAME Catherine Folk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Allegany County Infirmary Records		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION							
4222 IMMEDIATE CAUSE (A) Chronic Myocarditis							
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Osteoarthritis Deformans							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile Deterioration							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 15, 1955 to Aug 5, 1955 , that I last saw the deceased alive on Aug 5, 1955 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
SIGNATURE James B. McLean M.D.				ADDRESS (Street, city, town, state) 49 Greene St.		DATE SIGNED 8-6-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 8, 1955		NAME OF CEMETERY OR CREMATORY Old Coney Cemetery		LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. REC'D BY REGISTRAR Aug 8, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

11888

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

19

19

19

19

19

19

19

19

19

19

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19

BUREAU V. S.

AUG 9 1957

RECEIVED

AUG 8 1957

RECEIVED

George Washington, Baltimore, MD.

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07289

7398

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE	
(First) <u>ALBERT</u> (Middle) <u>LEWIS</u> (Last)		(Month) <u>Aug.</u> (Day) <u>23</u> (Year) <u>19 55</u>		male		white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
married		June 11, 1893		62 yrs.		retired miner	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
coal mines		Maryland		USA		John Lewis	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
Annie Yates		Yes <input checked="" type="checkbox"/> WW 1		213-09-9889		Mrs. Albert Lewis, Frostburg, Md.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				1ms			
443X IMMEDIATE CAUSE (A) <u>myocardial infarction</u>				3 years			
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>Aug 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 22</u> , 19 <u>55</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm Lane</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg Md</u> DATE SIGNED <u>Aug 24 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8-25-1955		F'bg. Memorial Park		Frostburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8-25-55</u>		<u>Wm Lane</u>		<u>J. R. Durst</u>		Frostburg, Md.	

03520

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print Name)

2. SEX and AGE

3. RACE

4. BIRTH DATE

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF SURVIVORS

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF BURIAL SOCIETY

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF DEPUTY CHIEF CLERK

24. SIGNATURE OF RECORDS SECTION

25. SIGNATURE OF STATISTICS SECTION

26. SIGNATURE OF INSPECTION SECTION

27. SIGNATURE OF LABORATORY SECTION

28. SIGNATURE OF RADIATION SECTION

29. SIGNATURE OF TOXICOLOGY SECTION

30. SIGNATURE OF BACTERIOLOGY SECTION

31. SIGNATURE OF VIROLOGY SECTION

32. SIGNATURE OF IMMUNOLOGY SECTION

33. SIGNATURE OF EPIDEMIOLOGY SECTION

34. SIGNATURE OF PUBLIC HEALTH SECTION

35. SIGNATURE OF COMMUNITY HEALTH SECTION

36. SIGNATURE OF SCHOOL HEALTH SECTION

37. SIGNATURE OF OCCUPATIONAL HEALTH SECTION

38. SIGNATURE OF ENVIRONMENTAL HEALTH SECTION

39. SIGNATURE OF NUTRITION SECTION

40. SIGNATURE OF PHYSICAL EDUCATION SECTION

41. SIGNATURE OF RECREATION SECTION

42. SIGNATURE OF ARTS AND CRAFTS SECTION

43. SIGNATURE OF MUSIC SECTION

44. SIGNATURE OF THEATRE SECTION

45. SIGNATURE OF FILM SECTION

46. SIGNATURE OF RADIO SECTION

47. SIGNATURE OF TELEVISION SECTION

48. SIGNATURE OF COMMERCE SECTION

49. SIGNATURE OF INDUSTRY SECTION

50. SIGNATURE OF TRANSPORTATION SECTION

51. SIGNATURE OF AGRICULTURE SECTION

52. SIGNATURE OF FORESTRY SECTION

53. SIGNATURE OF FISHERIES SECTION

54. SIGNATURE OF MINING SECTION

55. SIGNATURE OF CONSTRUCTION SECTION

56. SIGNATURE OF MANUFACTURING SECTION

57. SIGNATURE OF SERVICE SECTION

58. SIGNATURE OF EDUCATION SECTION

59. SIGNATURE OF RESEARCH SECTION

60. SIGNATURE OF DEVELOPMENT SECTION

61. SIGNATURE OF PLANNING SECTION

62. SIGNATURE OF EVALUATION SECTION

63. SIGNATURE OF MONITORING SECTION

64. SIGNATURE OF REPORTING SECTION

65. SIGNATURE OF ANALYSIS SECTION

66. SIGNATURE OF INTERPRETATION SECTION

67. SIGNATURE OF PRESENTATION SECTION

68. SIGNATURE OF DISSEMINATION SECTION

69. SIGNATURE OF OUTREACH SECTION

70. SIGNATURE OF EDUCATION SECTION

71. SIGNATURE OF RESEARCH SECTION

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107. SIGNATURE OF RESEARCH SECTION

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116. SIGNATURE OF DISSEMINATION SECTION

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133. SIGNATURE OF PLANNING SECTION

134. SIGNATURE OF EVALUATION SECTION

135. SIGNATURE OF MONITORING SECTION

136. SIGNATURE OF REPORTING SECTION

137. SIGNATURE OF ANALYSIS SECTION

138. SIGNATURE OF INTERPRETATION SECTION

139. SIGNATURE OF PRESENTATION SECTION

140. SIGNATURE OF DISSEMINATION SECTION

141. SIGNATURE OF OUTREACH SECTION

142. SIGNATURE OF EDUCATION SECTION

143. SIGNATURE OF RESEARCH SECTION

144. SIGNATURE OF DEVELOPMENT SECTION

145. SIGNATURE OF PLANNING SECTION

146. SIGNATURE OF EVALUATION SECTION

147. SIGNATURE OF MONITORING SECTION

148. SIGNATURE OF REPORTING SECTION

149. SIGNATURE OF ANALYSIS SECTION

150. SIGNATURE OF INTERPRETATION SECTION

151. SIGNATURE OF PRESENTATION SECTION

152. SIGNATURE OF DISSEMINATION SECTION

153. SIGNATURE OF OUTREACH SECTION

154. SIGNATURE OF EDUCATION SECTION

155. SIGNATURE OF RESEARCH SECTION

156. SIGNATURE OF DEVELOPMENT SECTION

157. SIGNATURE OF PLANNING SECTION

158. SIGNATURE OF EVALUATION SECTION

159. SIGNATURE OF MONITORING SECTION

160. SIGNATURE OF REPORTING SECTION

161. SIGNATURE OF ANALYSIS SECTION

162. SIGNATURE OF INTERPRETATION SECTION

163. SIGNATURE OF PRESENTATION SECTION

164. SIGNATURE OF DISSEMINATION SECTION

165. SIGNATURE OF OUTREACH SECTION

BUREAU V. S.

AUG 29 1955

RECEIVED

SMITHSONIAN INSTITUTION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After filing the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07290

7281

CERTIFICATE OF DEATH

DR. W.F. WILLIAMS

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		2 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 618 MARYLAND AVENUE			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
JAMES H. MANNING				AUGUST 20 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	3/1/1893	62 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machinist		B. & O. R.R.CO.		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES P. MANNING				MARY SHORES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
yes First WW		705-09-3451		MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8:19, 1955, to 8:20, 1955, that I last saw the deceased alive on 8:19, 1955, and that death occurred at 5:50A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
W.F. Williams				Cumberland		8-22-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug 22/55		Hillcrest Burial Park		Cumberland Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 22, 1955		Walter R. Hawk, M.D.		W.H. Knight		Cumberland Md	

117300

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Birth Date: May 1918

Dr. W. W. Williams

At and to the residence of the deceased

Place of Death

John Henry Williams

Age 32

Occupation

City of Baltimore

3 Days

County of Baltimore

2100 North Avenue

General Hospital

State of Maryland

1942

Death Certificate

21/1/42

21/1/42

White

Male

Married

James P. Williams

1749-3421

21/1/42

State of Maryland

1942

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BUREAU V. S.

AUG 24 1942

RECEIVED

Investigation Bureau

1942

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08274

7399 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Md.</u>		COUNTY <u>Alleg.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>43 Westernport</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>43 Westernport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Stoney Run Road</u>				STREET ADDRESS (If rural give location) <u>Stoney Run Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Clyde Vivian Marsh</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 13 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 19, 1902</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mining</u>		11. BIRTHPLACE (State or foreign country) <u>Culpepper, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Montgomery Marsh</u>				14. MOTHER'S MAIDEN NAME <u>-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-05-0996</u>		17. INFORMANT & ADDRESS <u>Clyde V. Marsh, Jr., Westernport, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Anterograde heart disease with myocardial infarction & congestive heart failure.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 18, 1955</u> , to <u>Aug. 13, 1955</u> , that I last saw the deceased alive on <u>Aug. 13, 1955</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James A. Hester</u>				DATE SIGNED <u>Piedmont, Virginia</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-16-55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Sept. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Joan C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. A. Boal Westernport Md.</u>		ADDRESS	

9/23/55
Mab.

Outside of
City Limits

7313

07291

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>X</u> TOWN <u>Rural</u> <u>Cumberland</u>		<u>40</u> years.		TOWN <u>Rural</u> <u>Cumberland</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#3 Bedford Road.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D.#3 Bedford Road</u>			
3. NAME OF DECEASED: (First) <u>Adaline</u>		(Middle) <u>M.</u>		(Last) <u>Mauk</u>		4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>widow</u>		8. DATE OF BIRTH: <u>Nov. 28-1869</u>	
9. AGE last birthday: <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Flintstone Creek, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>J.B.Wigfield</u>				14. MOTHER'S MAIDEN NAME: <u>Caroline Hartsock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Cumberland, Md. (daughter) Mrs. E.B. Barnes, R.F.D.#3</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>422.2</u> Immediate cause (a) <u>Myocardial failure</u> DUE TO		<u>gradual</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Invalid & bedfast since then. neck. Fracture of left femur at surgical</u>		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		21c. (City or town) (County) (State) <u>(rural) Cumberland, Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) <u>June 22/53 A. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Legs gave away, she fell and fractured left femur.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <u>H.V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 25-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Aug 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>R.D. S. Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Treant, M.D.</u>		24. FUNERAL DIRECTOR <u>William S. Light, Cumberland, Md.</u>	

BUREAU V. S.

AUG 29 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07292

7310 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>3 Weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lonaconing</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS <u>Jackson Street</u>		/	
3. NAME OF DECEASED (Type or Print) <u>AGNES</u> (First) <u>MERRBAUGH</u> (Middle) (Last)				4. DATE OF DEATH <u>Aug. 12th</u> 19 <u>55</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 30. 18 1870</u>	9. AGE last birthday <u>84</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work Own Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. William Gardner (Daughter)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)		<u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO		<u>Chronic Heart Disease</u>		<u>Yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		DUE TO					
STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> , to <u>Aug 13, 1955</u> , that I last saw the deceased alive on <u>August 13, 1955</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.B. Davis</u>		M.D. <u>Frostburg, Md</u>		ADDRESS (Street, city, town, state) <u>8/13/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery, Moscow, MD.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>8-15-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>		ADDRESS	

1935

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Reg. No. 10

1. Name of deceased (Print or write full name)

2. Sex (Male or Female) and Age (Years, Months, Days)

3. Place of birth (City, State, Country)

4. Date of death

5. Cause of death (State immediately and in detail)

6. Signature of physician

7. Signature of registrar

8. Signature of undertaker

9. Signature of medical examiner

10. Signature of coroner

BUREAU V. S.

AUG 18 1935

RECEIVED

11. Name of funeral home or undertaker

12. Name of cemetery

13. Date of burial

14. Name of church

ENCLOSURES

Vertical text on the right margin, likely containing administrative notes or filing information.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7282 CERTIFICATE OF DEATH

07293

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		LENGTH OF STAY (in this place) 30 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVENUE				STREET ADDRESS (If rural give location) 803 MANNS TERRACE		1	
3. NAME OF DECEASED (Type or Print) MARTHA A. PATTERSON				4. DATE OF DEATH (Month) (Day) (Year) AUGUST 1, 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH DECEMBER 13, 1871		9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE E. MASON				14. MOTHER'S MAIDEN NAME ZANIA COMPTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.2 IMMEDIATE CAUSE (A) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH 1 yr 7	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) Ravages of age							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/2/52, 19 to 8/1/55, 19, that I last saw the deceased alive on 8/1/55, 19, and that death occurred at 1:08 P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		DATE THEREOF 8-4-1955		NAME OF CEMETERY OR CREMATORY HillCrest Burial Park		LOCATION (City, town, or county) Cumberland, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR Aug. 2, 1955		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	

Will not corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7283

CERTIFICATE OF DEATH

07294

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		45 MINUTES		TOWN KITZMILLER, rural		11X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		STREET ADDRESS		(If rural give location)	
60				STAR ROUTE		✓	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JUDY (Middle) ANN (Last) PAUGH				(Month) AUGUST (Day) 4 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	SINGLE	JAN. 20, 1947	8 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Student		School		KEYSER, W.VA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DAVID WILLIAM PAUGH				BETTY RAY PAUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
057.1 IMMEDIATE CAUSE (A)				Waterhouse Friedrichsen Syndrome 1 day			
ANTECEDENT CAUSE(S) DUE TO (B)				Pneumonia at upper and lower lobe 2 1,			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Septicemia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				1-2 1.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 4, 19 55, to Aug 4, 19 55, that I last saw the deceased alive on Aug 4, 19 55, and that death occurred at 1:00 P.M. from the causes and on the date stated above.							
SIGNATURE R. A. Reiter				ADDRESS (Street, city, town, state) DATE SIGNED 112 Bedford St., Cumberland, Md. 8/4/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 6, 1955		I. O. O. F. Cemetery		Elk Garden, West Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug 5, 1955		Walter R. Frantz, M.D.		O. A. Sharpley, Blue		O. A. Sharpley	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1 With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07295

7284

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY ALLEGANY MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND LENGTH OF STAY (in this place) 24 DAYS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE W.VA. COUNTY TUCKER CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAVIS STREET ADDRESS (If rural give location) 85X-3			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) FLORA A PHELPS				4. DATE OF DEATH (Month) (Day) (Year) AUGUST 18 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 27, 1897	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISRAEL W. WHITT				14. MOTHER'S MAIDEN NAME MARY E. TAYLOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170X IMMEDIATE CAUSE (A) Carcinoma breast, right with						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) metastasis to spine, liver and (C) terminal Cachexia							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION April 1, 1953		19b. MAJOR FINDINGS OF OPERATION Extensive Carcinoma breast, Right				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <input type="checkbox"/>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from May 26, 1953 , to Aug 18, 1955 , that I last saw the deceased alive on Aug 18, 1955 , and that death occurred at 9:00A.M. from the causes and on the date stated above. SIGNATURE W. M. Fawcett Jr. M.D. ADDRESS (Street, city, town, state) Cumberland Md DATE SIGNED Aug 18, 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug 21-55		NAME OF CEMETERY OR CREMATORY Davis		LOCATION (City, town, or county) (State) Davis W. Va.	
24. REC'D BY REGISTRAR Aug. 19, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Frizzle		ADDRESS Davis W. Va.	

BUREAU V. 5

AUG 22 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08288

8289

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Md.</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>3 wks.</u>		TOWN <u>Frostburg, Md.</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Miner's Hospital</u>				<u>142 E. College Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Mary Jane Rank</u>				<u>8-31-55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>6-2-1871</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Teacher</u>		<u>Public School</u>		<u>Eckhart, Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Dando</u>				<u>Sarah Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Ave. Frostburg, Md.</u>	
				<u>Lindley Rank, Son. 142 E. College</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>10 years</u>	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
0022 (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>several years</u>	
<u>Fibrotic - Pulmonary Tuberculosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/27</u> , 19 <u>55</u> , to <u>8/31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/31</u> , 19 <u>55</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Markus Rothstein M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 Broadway - Frostburg, Md.</u>		DATE SIGNED <u>9/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-3-1955</u>		<u>Frostburg Memorial</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>9-3-55</u>		<u>Mrs Nancy N. Rae</u>		<u>Dean H. Mattingly, Frostburg</u>		<u>Md.</u>	

CERTIFICATE OF DEATH

STATE OF ILLINOIS DEPARTMENT OF HEALTH

Page No. 1

1. Name of Deceased

2. Sex

3. Race

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Time of Death

8. Cause of Death

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Health Officer

15. Signature of Burial Officer

16. Signature of Undertaker

17. Signature of Cemetery

18. Signature of Funeral Home

19. Signature of Mortician

20. Signature of Embalmer

21. Signature of Preparer

22. Signature of Assistant

23. Signature of Embalmer

24. Signature of Preparer

25. Signature of Assistant

26. Signature of Embalmer

27. Signature of Preparer

28. Signature of Assistant

29. Signature of Embalmer

30. Signature of Preparer

31. Signature of Assistant

32. Signature of Embalmer

33. Signature of Preparer

34. Signature of Assistant

35. Signature of Embalmer

36. Signature of Preparer

37. Signature of Assistant

38. Signature of Embalmer

39. Signature of Preparer

40. Signature of Assistant

41. Signature of Embalmer

42. Signature of Preparer

43. Signature of Assistant

44. Signature of Embalmer

45. Signature of Preparer

46. Signature of Assistant

47. Signature of Embalmer

48. Signature of Preparer

49. Signature of Assistant

50. Signature of Embalmer

49. Signature of Preparer

50. Signature of Assistant

51. Signature of Embalmer

50. Signature of Preparer

51. Signature of Assistant

52. Signature of Embalmer

BUREAU V. S.

13 1955

RECEIVED

1-2-1955

1-2-1955

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>29 yrs.</u>		TOWN <u>Cumberland</u>		<u>92</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>437 Williams St.</u>				STREET ADDRESS (If rural, give location) <u>437 Williams St.</u>			
3. NAME OF DECEASED: (First) <u>Frank</u>		(Middle) <u>Lewis</u>		(Last) <u>Reed.</u>		4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widower</u>		8. DATE OF BIRTH: <u>Feb. 2-1882</u>		9. AGE last birthday: <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>retired passenger conductor, B&O.R.Ry.</u>				<u>Corrigansville, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Reed</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Fazenbaker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>(Housekeeper)</u>		17. INFORMANT & ADDRESS: <u>Virginia Sunderland, Cumberland, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u>						<u>sudden</u>	
DUE TO							
Antecedent cause(s) (b) <u>Coronary sclerosis.</u>							
Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>A.V. Deming M.D.</u>		<u>M.D.</u>		<u>Aug. 18-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Aug 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		24. FUNERAL DIRECTOR <u>Louis Klein, Inc.</u>		ADDRESS <u>" "</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 22 1955

BUREAU V. S.

7286

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALEEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		8 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL				204 WILMONT AVE.			
MEMORIAL AVE.							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ROBERT (Middle) EDWARD (Last) ROBINSON				(Month) (Day) (Year)			
				AUG. 24 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED	JAN 14 1881	74 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired janitor		Board of education		WEST VIRGINIA, Three Churches		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Sanford Robinson				Susan Yost			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No.		214-07-0569		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
493X IMMEDIATE CAUSE (A) Pneumonia				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 8/15, 1955, to 8/24, 1955, that I last saw the deceased alive on 8/23, 1955, and that death occurred at 8:50AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Dr. J. H. Lee Jr.				M.D. 456 N. Centre St. Cumberland		8/24/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8/27/55		Frostburg Memorial Park		Frostburg, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 25, 1955		Walter R. Frank, M.D.		H. Wayne George		Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

7319

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0722893
Reg. Dist. 93

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 10

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Mt. Savage</u>	LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Mt. Savage</u>	<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location) <u>1</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) <u>Ruth</u>	(Middle) <u>Agnes</u>	(Last) <u>Robison</u>	(Month) <u>Aug.</u>	(Day) <u>8</u>	(Year) <u>19 55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>June 24-1893</u>		
9. AGE last birthday: <u>62</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY:		
11. BIRTHPLACE (State or foreign country): <u>Frostburg, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Patrick Tighe</u>			14. MOTHER'S MAIDEN NAME: <u>Helena Garlitz</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.: <u>none</u>		
17. INFORMANT & ADDRESS: <u>(son) James Robison, Mt. Savage, Md.</u>					

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				sudden	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Coronary sclerosis with Angina syndrome</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				2 yrs.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE					
<u>H. V. Deming M.D.</u> <u>H. V. Deming M.D.</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 8-1955</u> DEPUTY MEDICAL EXAMINER * ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>Aug. 11, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Michael's Cemetery</u>	
LOCATION (City, town, or county) (State): <u>Frostburg, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS: <u>Carroll Inc. Remitt & John L. Hafer, Cumberland, Md.</u>			
DATE REC'D BY LOCAL REG. <u>Aug. 19, 1955</u>		REGISTRAR'S SIGNATURE: <u>Carroll Inc. Remitt & John L. Hafer, Cumberland, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 15 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7311

CERTIFICATE OF DEATH

07299

6

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
43 TOWN <u>Westonport</u> 50 yrs				TOWN <u>Westonport</u> 43			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>207 Maryland Ave</u>				STREET ADDRESS (If rural give location) <u>207 Maryland Ave</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY Ella SALESKY</u>				<u>Aug 22 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>11 June 1897</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Own home</u>		<u>Winchester, VA</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>HENRY Gentry</u>				14. MOTHER'S MAIDEN NAME <u>Amanda CARVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>207 Md Ave John SALESKY Westonport, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.2 IMMEDIATE CAUSE (A) <u>Acute Cardiac Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Three Hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>						<u>Two Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 21</u> , 19 <u>55</u> , to <u>Aug 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 21</u> , 19 <u>55</u> , and that death occurred at <u>12:58 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul B. Wilson</u>		M.D. <u>Piedmont, W. Va.</u>		DATE SIGNED <u>Aug 23, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Phila Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westonport, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <u>Westonport, Md</u>	
DATE <u>Aug 23, 1955</u>							

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07300

7287 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <u>Cumberland</u>		45 yrs.		TOWN <u>Cumberland</u>		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 29 W. First Street				29 W. First St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u>		(Middle) <u>D.</u>		(Last) <u>Schad</u>		(Month) (Day) (Year)	
						Aug. 26 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Sept. 22, 1880	74 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>sewing</u>)		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (State or foreign country) <u>Eckhart, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Donahue</u>				14. MOTHER'S MAIDEN NAME <u>Jane Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-4793</u>		17. INFORMANT & ADDRESS <u>Mrs. Helen Buskey, 25 Oak St., Ct</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						2 yrs.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO						2 days	
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 25, 1955</u> to <u>Aug 26, 1955</u> That I last saw the deceased alive on <u>Aug 25, 1955</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Clay E. Lunn</u> M.D.				DATE SIGNED <u>Aug 26, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

AUG 30 1955

RECEIVED

1 **WITHIN 24 HOURS** after death. The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07301

Item 18 Film G185 8-19-55 am

CERTIFICATE OF DEATH

DR. MIRKIN 7288

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		22 DAYS		TOWN SWANTON, rural		11X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL				Mt. Zion Community			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) LEOLA		(Middle) P.		(Last) SHARPLESS		(Month) (Day) (Year)	
						AUGUST 13 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	SINGLE	DECEMBER 23, 1889	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK			Own Home		MARYLAND		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
FRANK SHARPLESS, Francis R.				ELIZABETH FULMER (Fulmer)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
053.0 IMMEDIATE CAUSE (A) <u>Myocardia</u>						23 days	
ANTECEDENT CAUSE(S) DUE TO <u>Amuria</u>						23 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Staphylococcus infection</u>						29 days	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>(no injury) Myocardial disease, coronary artery disease</u>						6?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/21, 1955, to 8/13, 1955, that I last saw the deceased alive on 8/13, 1955, and that death occurred at 10:10 PM, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Shirley D. Pearson</u>		M.D. 50 Pershing St. Cumberland, Md.		8/14/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 16/55		Sharpless Cemetery		Mt. Zion, Garrett Co., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 15, 1955		Walter R. Frantz, M.D.		O. A. L. Sharpless		Blaine, W. Va.	

10570

BUREAU V. J.

AUG 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7312

CERTIFICATE OF DEATH

07302

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>20 minutes</u>		TOWN <u>Jennings</u>		TOWN <u>11X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>EDITH SHEWBRIDGE</u>				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9 - 6 - 1900</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Midlothian</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alec McGregor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Willetts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Ivan Shewbridge, Jennings, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>Hypertension</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 12, 1955</u> to <u>April 12, 1955</u> , that I last saw the deceased alive on <u>April 12, 1955</u> , and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>WOM Lane</u>		M. D. <u>Frostburg Md</u>		ADDRESS (Street, city, town, state) <u>Aug 14 1955</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8 - 15 - 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Miss Nancy H. R. B.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B.H. Montesant</u>		ADDRESS <u>23 E. Main Frostburg, Md.</u>	
DATE <u>8-15-55</u>							

07305

MAILED TO STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

INTERVIEW

DATE OF INTERVIEW

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

DATE OF DEATH

DATE OF DEATH

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BUREAU V. 2

AUG 18 1955

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7289

07303
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL) _____
 OR and give nearest town) _____
 TOWN Cumberland LENGTH OF STAY
 (in this place) _____

HOSPITAL OR Dead on arrival at the
 INSTITUTION OR
 STREET ADDRESS Sacred Heart Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town)
 OR
 TOWN Cumberland

STREET ADDRESS (If rural, give location)
403 South Cedar St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

DonaldAlbertShoap

4. DATE OF DEATH

(Month)

(Day)

(Year)

Aug. 2119 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

malewhiteMarriedMarch 21-190748

yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of work life)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Tire and Motor Vehicle ReproductionGen. Reading Works—Chambersburg, Pa.U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Samuel ShoapCarrie Osler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

161-12-6870

17. INFORMANT & ADDRESS:

(wife) Stella Blubaugh Shoap, City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause

(a)

Coronary occlusion

DUE TO

Antecedent cause(s)Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

Coronary sclerosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
sudden2 yrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at Not while work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER ☐
 DEPUTY MEDICAL EXAMINER ☒
 ASSISTANT MEDICAL EXAM. ☐

Aug. 22-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial8/24/55Zion Memorial Cem.Cumberland, Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug. 23, 1955Walter R. Frantz, M.D.H. Wayne George Cumberland, Md.

BUREAU V. 3.

AUG 25 1955

RECEIVED

CERTIFICATE OF DEATH

07304

Reg. Dist. No. 4

7290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland,		35 yrs.		TOWN Cumberland,		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 819 Fayette St.,				STREET ADDRESS (If rural give location) 819 Fayette St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JOHN (Middle) ALOYSIUS (Last) SINGER				(Month) August (Day) 23, (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
Male	White	Married	May 2, 1879	76 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired service station opr, Service station				St. Leon, Indiana		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Albert Singer				Mary Roell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No,		None		Mrs. Mary Singer 819 Fayette St., Cumb.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
792X IMMEDIATE CAUSE (A) Uremia							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
Arthritis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/23 , 19 55 , to 8/23 , 19 55 , that I last saw the deceased alive on 8/23 , 19 55 , and that death occurred at 5:15 A. M., from the causes end on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
Les J. Ley Jr.		M.D. 456 N. Centre St. Cumberland		8/25/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8/26/55		Hillcrest Burial Park		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 26, 1955		Walter R. Frantz, M.D.		H. Wayne George		Cumberland, Md.	

INSTRUCTIONS

1. Within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

3. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

07304

CERTIFICATE OF DEATH

1955

Reg. Code 14

1. NAME OF DECEASED

MARY ANN ALLEN

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. PLACE OF INTERMENT

12. NAME OF FUNERAL HOME

13. NAME OF PHYSICIAN

14. NAME OF CORONER

15. NAME OF MEDICAL EXAMINER

16. NAME OF REGISTRAR

17. NAME OF CLERK

18. NAME OF ASSISTANT CLERK

19. NAME OF NURSE

20. NAME OF CHURCH

21. NAME OF CEMETERY

22. NAME OF FUNERAL HOME

23. NAME OF PHYSICIAN

24. NAME OF CORONER

25. NAME OF MEDICAL EXAMINER

26. NAME OF CLERK

27. NAME OF ASSISTANT CLERK

28. NAME OF NURSE

29. NAME OF CHURCH

30. NAME OF CEMETERY

31. NAME OF FUNERAL HOME

32. NAME OF PHYSICIAN

33. NAME OF CORONER

34. NAME OF MEDICAL EXAMINER

35. NAME OF CLERK

36. NAME OF ASSISTANT CLERK

37. NAME OF NURSE

38. NAME OF CHURCH

39. NAME OF CEMETERY

40. NAME OF FUNERAL HOME

41. NAME OF PHYSICIAN

42. NAME OF CORONER

43. NAME OF MEDICAL EXAMINER

44. NAME OF CLERK

45. NAME OF ASSISTANT CLERK

46. NAME OF NURSE

47. NAME OF CHURCH

48. NAME OF CEMETERY

49. NAME OF FUNERAL HOME

50. NAME OF PHYSICIAN

BUREAU V. 2

AUG 29 1955

RECEIVED

20011001204

NO RECEIVING DIRECTLY AT
DEPARTMENT OF HEALTH, BALTIMORE, MD.

100-111-104

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Cumberland		COUNTY	Allegany	
TOWN	Cumberland		CITY (If outside corporate limits write RURAL and give nearest town)	Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	443 Waverly Terrace		STREET ADDRESS	(If rural, give location) 443 Waverly Terrace	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	Lona	Belle	Slonaker	Aug.	27 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Female	white	Widow	Oct. 7-1874	80 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	Housewife		10b. KIND OF BUSINESS OR INDUSTRY:	Own home	
11. BIRTHPLACE (State or foreign country):	De Haven, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Richard DeHaven			14. MOTHER'S MAIDEN NAME: Mary Jane Whitacre		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no		none		(son) Ray H. Slonaker, Cumberland, Md.	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
442X Immediate cause (a) Myocardial failure DUE TO Antecedent cause(s) (b) Cardio-vascular-renal disease. Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			Gradual several years.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
H.V. Deming M.D.		ASSISTANT MEDICAL EXAM. <input type="checkbox"/> Aug. 27/55	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 30, 1955	Bethel Methodist Cem	Near Low Low, West Virginia
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
Aug. 29, 1955	Walter K. Frantz, M.D.	John J. Rafer, Cumberland, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 30 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07306

7313

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg, Md.</u>		<u>1 day</u>		TOWN <u>Eckhart, Md.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
<u>61 Miners Hospital</u>				<u>Box 54</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>Walter</u> (Last) <u>Solomon</u>				(Month) (Day) (Year)			
				<u>8</u> <u>8</u> <u>1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH	
				<u>1 - 9 - 1882</u>		9. AGE last birthday <u>73</u> yrs.	
						IF UNDER 1 YEAR	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Uniontown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Solomon</u>				14. MOTHER'S MAIDEN NAME <u>Susan King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>215-20-6038</u>		17. INFORMANT & ADDRESS <u>R.D.No.1, Box 142 Md. Mrs. Clarence Michaels Frostburg.</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/7</u> , 19 <u>55</u> , to <u>8/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/9</u> , 19 <u>55</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John C. Stewart</u> M.D.				ADDRESS (Street, city, town, state) <u>Worthway Rd</u>		DATE SIGNED <u>8/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		LOCATION (City, town, or county) <u>Eckhart Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. Clarence D. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Monteen</u>		ADDRESS <u>23 E. Main Frostburg, Md.</u>	
DATE <u>8-12-55</u>							

Mrs. Nancy H. Bueh

07305

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

THE CERTIFICATE OF DEATH

Reg. No. 10-10

1. USUAL RESIDENCE (HOUSE OR BUSINESS)

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. COUNTY

6. BIRTH DATE

7. BIRTH PLACE

8. DECEASED DATE

9. BOX NO.

10. MARRIAGE NO.

11. DECEASED

12. DECEASED

13. DECEASED

14. DECEASED

15. DECEASED

16. DECEASED

17. DECEASED

18. DECEASED

19. DECEASED

20. DECEASED

21. DECEASED

22. DECEASED

23. DECEASED

24. DECEASED

RECEIVED

BUREAU V. B.

AUG 15 1955

RECEIVED

25. DECEASED

26. DECEASED

27. DECEASED

28. DECEASED

29. DECEASED

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7292

CERTIFICATE OF DEATH

07307

4

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>18 days</u>		TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>120 Winton Place</u>			
3. NAME OF DECEASED (Type or Print) <u>Eva Cecelia Speir</u>				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>1</u> (Year) <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/1/93</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Whitefield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
581.0 IMMEDIATE CAUSE (A) <u>Hepatic coma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>cinchonin of the liver</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-3-</u> <u>19 54</u> , to <u>8-1-</u> <u>19 55</u> , that I last saw the deceased alive on <u>7-31-</u> <u>19 55</u> , and that death occurred at <u>230 A</u> M. from the causes and on the date stated above. SIGNATURE <u>L. Morris</u> ADDRESS (Street, city, town, state) <u>576 Green St. Cumberland Md</u> DATE SIGNED <u>8-1-55</u> M.D. <u>576 Green St. Cumberland Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-3-1955</u>		NAME OF CEMETERY OR CREMATORY <u>S.S. Peter & Paul Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Aug. 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Write R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

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BUREAU V. 1

AUG 4 1955

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7293

CERTIFICATE OF DEATH

07308

Reg. Dist. No. 4

DR. WEISMAN

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY OR TOWN CUMBERLAND		LENGTH OF STAY (in this place) 1 DAY		CITY OR TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS 249 VIRGINIA AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JERRY		(Middle) SPERA		(Last)		(Month) AUGUST 17 (Day) 19 (Year) 55	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUGUST 18, 1900	9. AGE last birthday 54 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY Confectionery		11. BIRTHPLACE (State or foreign country) ITALY, NAPLES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH SPERA				14. MOTHER'S MAIDEN NAME ANNA MARIE ALOCIK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Acute myocardial failure				INTERVAL BETWEEN ONSET AND DEATH instantly			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Sclerosis				5 year			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic Heart Disease				5 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Duodenal ulcer, asthma				5 year			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 30, to 8/17, 19 55, that I last saw the deceased alive on 8/16, 19 55, and that death occurred at 2:00A M, from the causes and on the date stated above.							
SIGNATURE Dr. Weisman MD				ADDRESS (Street, city, town, state) M.D. Cumberland Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 8-20-1955		NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
				LOCATION (City, town, or county) Cumberland, Md.		DATE SIGNED 8/17/55	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 20, 1955		Walter R. Frank, M.D.		James F. Scarpelli		Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

07300

Reg. Dist. No. 1

DR. WEINMAN

1. PLACE OF DEATH

2. MANNER OF DEATH (Check one)

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

230 YORK WAVE AVENUE

ALLEGAND HOSPITAL

3. PLACE OF DEATH

ALLEGAND

ALLEGAND

MALE

WHITE

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND HOSPITAL - ALLEGAND, MD

IN PROPER CONNECTION

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

ALLEGAND

BUREAU V. S.

AUG 24 1915

RECEIVED

RECEIVED
ALLEGAND HOSPITAL
ALLEGAND, MD
AUG 24 1915

RECEIVED

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7294

CERTIFICATE OF DEATH

07309

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
02 TOWN <u>Cumberland</u>		Life		TOWN <u>Cumberland</u>		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>716 Shriver Avenue</u>				<u>716 Shriver Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>GEORGE H. STRONG</u>				<u>Aug. 25, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>June 16, 1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Conductor-Retired</u>			<u>Railroad</u>		<u>Cumberland, Md.</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George H. Strong</u>				<u>Mary Hummel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Josephine Kern, Coulter, Pa.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A)				<u>Myocardial Failure</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Obesity</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>3 am</u>			
				<u>2</u>			
				<u>2</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 18, 1955</u> , to <u>Aug 25, 1955</u> , that I last saw the deceased alive on <u>Aug 24, 1955</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. H. Kight</u>				ADDRESS (Street, city, town, state) <u>M. D. Cumberland Ind</u>		DATE SIGNED <u>8/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 29, 1955</u>		<u>Ebenezer Cemetery</u>		<u>Romney, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>Aug. 29, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>William H. Kight, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Outside of
City Limits

7320

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07310
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND	STATE <u>Md.</u> COUNTY <u>Allegany</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Town 1) Cumberland</u>		LENGTH OF STAY (in this place) <u>30 yrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rural) Cumberland</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. Braddock Farm</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. #1 Braddock Farm</u>			
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) (Middle) (Last) <u>Henry</u> <u>Sturtz</u>			OF DEATH <u>Aug.</u> <u>26</u> <u>19</u> <u>55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>Male</u>	<u>white</u>	<u>Divorced</u>	<u>Sept 22-1876</u>	<u>78</u>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Laborer - Kelley S-Tire Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
				<u>near-Hyndman.Pa.</u>	<u>U.S.A.</u>
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Soloman Sturtz</u>			<u>Eva Logue</u>		
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
<u>no</u>		<u>214-07-0172</u>	<u>R.F.D. #1 Braddock F. Satie Corley-Cumberland, Md.</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
<u>420.1</u> Immediate cause (a)..... <u>Coronary occlusion</u> DUE TO				
Antecedent cause(s) (b)..... <u>Coronary sclerosis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>3 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 26-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>				
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Aug. 27, 1955</u>	<u>Hyndman Cemetery</u>	<u>Hyndman, Bedford Co. Pa.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Aug. 27, 1955</u>	<u>Walter R. Frank, M.D.</u>	<u>Harvey H. Leifer</u>	<u>Hyndman, Pa.</u>	

RECEIVED

AUG 30 1955

BUREAU V. S.

7295

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALEEGANY	
CITY (if outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
02 TOWN CUMBERLAND		46		TOWN CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
60 MEMORIAL HOSPITAL MEMORIAL AVE.				208 SARATOGA ST.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ALBAN		(Middle) C.		(Last) THOMPSON		(Month) (Day) (Year)	
						AUGUST 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	MAY 25, 1881	74 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired Judge)		10b. KIND OF BUSINESS OR INDUSTRY (Juvenile Court)		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM THOMPSON				14. MOTHER'S MAIDEN NAME AGNES SCHUYLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Myocardial Degeneration						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/4, 1955, to 8/19, 1955, that I last saw the deceased alive on 8/19, 1955, and that death occurred 9:05 PM M, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Doan H. Ley Jr.		8/22/55		Hillcrest Burial Park Cumberland		Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		Reg. 23, 1955		Winters R. Frantz, M.D.		Louis Steins, Inc. Cumberland, Md.	

INSTRUCTIONS

1 Within corporate limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS A15C 1-55 10M

02311

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED

WILLIAM THOMPSON

WILLIAM THOMPSON

WILLIAM THOMPSON

WILLIAM THOMPSON

2. SEX

MALE

MALE

MALE

3. RACE

WHITE

WHITE

WHITE

4. DATE OF BIRTH

MAY 25, 1890

MAY 25, 1890

MAY 25, 1890

5. PLACE OF BIRTH

BALTIMORE, MD

BALTIMORE, MD

BALTIMORE, MD

6. PLACE OF DEATH

BALTIMORE, MD

BALTIMORE, MD

BALTIMORE, MD

7. DATE OF DEATH

AUG 25, 1919

AUG 25, 1919

AUG 25, 1919

8. TIME OF DEATH

10:00 AM

10:00 AM

10:00 AM

9. CAUSE OF DEATH

HEART DISEASE

HEART DISEASE

HEART DISEASE

10. PLACE OF INTERMENT

BALTIMORE, MD

BALTIMORE, MD

BALTIMORE, MD

11. SIGNATURE OF PHYSICIAN

WILLIAM THOMPSON

WILLIAM THOMPSON

WILLIAM THOMPSON

12. SIGNATURE OF REGISTRAR

WILLIAM THOMPSON

WILLIAM THOMPSON

WILLIAM THOMPSON

13. SIGNATURE OF WITNESSES

WILLIAM THOMPSON

WILLIAM THOMPSON

WILLIAM THOMPSON

14. SIGNATURE OF DECEASED

WILLIAM THOMPSON

WILLIAM THOMPSON

WILLIAM THOMPSON

15. SIGNATURE OF DECEASED

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16. SIGNATURE OF DECEASED

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17. SIGNATURE OF DECEASED

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18. SIGNATURE OF DECEASED

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20. SIGNATURE OF DECEASED

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31. SIGNATURE OF DECEASED

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33. SIGNATURE OF DECEASED

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35. SIGNATURE OF DECEASED

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36. SIGNATURE OF DECEASED

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37. SIGNATURE OF DECEASED

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40. SIGNATURE OF DECEASED

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41. SIGNATURE OF DECEASED

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42. SIGNATURE OF DECEASED

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43. SIGNATURE OF DECEASED

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44. SIGNATURE OF DECEASED

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45. SIGNATURE OF DECEASED

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46. SIGNATURE OF DECEASED

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47. SIGNATURE OF DECEASED

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48. SIGNATURE OF DECEASED

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WILLIAM THOMPSON

49. SIGNATURE OF DECEASED

WILLIAM THOMPSON

WILLIAM THOMPSON

WILLIAM THOMPSON

BUREAU V. 2

AUG 25 1919

RECEIVED

MORTUARY

MORTUARY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7314

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07312
Reg. Dist.

No. 6

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Town, Westernport</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Bloomington</u> <u>118-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 135 about 1 mile east of Westernport.</u>				STREET ADDRESS (If rural, give location) <u>Main St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Fredrick</u> <u>Jerald</u> <u>Tichnell</u>				4. DATE OF DEATH <u>Aug. 27</u> <u>19</u> <u>55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>June 6-1918</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Feed Store</u>		9. AGE last birthday: <u>37</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Bloomington, Md.</u>	
13. FATHER'S NAME: <u>Cleaver Tichnell</u>				14. MOTHER'S MAIDEN NAME: <u>Lydia Barward.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>219-13-9561</u>		17. INFORMANT & ADDRESS: <u>Cards in pocket book.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>829X</u> Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last				(a) <u>Intracranial hemorrhage due to a fractured left side.</u> DUE TO (b) <u>Intrathoracic hemorrhage due to crushed ribs</u> DUE TO (c) <u>Automobile accident, ran off of road.</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Injury highway-135 near- Westernport, Allegany Md.</u>		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug. 27/55</u> <u>2.05</u> <u>A. M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>speed.</u> <u>Presume excessive</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 27-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>8-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
DATE REC'D BY LOCAL REG. <u>8-29-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jean C. Kelly</u>		24. FUNERAL DIRECTOR <u>E. J. Bone</u>		ADDRESS <u>Westernport Md.</u>	

RECEIVED

AUG 30 1965

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
02 TOWN <u>Cumberland</u>		27 yrs.	TOWN <u>Cumberland</u> 02		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Memorial Hospital.</u>			STREET ADDRESS (If rural, give location) <u>115 Mary St.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
(Type or Print) <u>Harry Ashby Twigg</u>			<u>Aug. 8 19 55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>Male</u>	<u>white</u>	<u>Married</u>	<u>Oct. 8-1900</u>		<u>54</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Car Repairman</u>		<u>B&O.R.Ry.</u>	<u>Spring Gap, Md.</u>		<u>U.S.A.</u>
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Dennis Twigg</u>			<u>Mary Shryock</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
<u>no</u>		<u>220-10-9159</u>	<u>(wife) Mary Twigg, Cumberland, Md.</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
322.0 Immediate cause (a) <u>Coronary occlusion</u>				<u>sudden</u>	
DUE TO					
Antecedent cause(s) (b) <u>Coronary sclerosis</u>				<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c) <u>Acute alcoholism</u>				<u>2 weeks.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE					
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		M. D. <u>Aug. 8-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>8/10/55</u>		<u>Mt. Taber Meth. Cem.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Aug. 9, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>John J. Hafer, Cumberland, Md.</u>	

RECEIVED

AUG 10 1955

BUREAU V. S.

1
With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7297

CERTIFICATE OF DEATH

07314

Reg. Dist. No. 4

INSTRUCTIONS

1
The law requires that the death certificate be executed within 24 hours after death.
The bottom copy may be retained by the hospital or attending physician.
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>15 Hours</u>		OR TOWN <u>Cresaptown, Md.</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Mary</u> (Middle) <u>Ann</u> (Last) <u>Warner</u>				<u>8/14-1955</u> 19			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Baby Girl</u>	8. DATE OF BIRTH <u>8/14, 1955</u>	9. AGE last birthday yrs. <u>15</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Warner</u>				14. MOTHER'S MAIDEN NAME <u>Marion Skelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Fred Warner, Cresaptown Md.</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>19 hours</u>	
754.4 IMMEDIATE CAUSE (A) <u>congenital malformation of heart</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>cor. in. ocular</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>8-14-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-14-1955</u> , to <u>8-14-1955</u> , that I last saw the deceased alive on <u>8-14-1955</u> , and that death occurred at <u>7:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L. M. King</u>				ADDRESS (Street, city, town, or county) <u>730 P. Hillcrest Burial Park, Cumberland, Md.</u>		DATE SIGNED <u>8-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Aug. 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Md.</u>	

2085264382

CERTIFICATE OF DEATH

07514

Reg. No. 114

1. Name of deceased (Print or type)

2. Place of death

3. Date of death

4. Time of death

5. Age of deceased

6. Sex of deceased

7. Race of deceased

8. Marital status

9. Occupation

10. Cause of death

11. Immediate cause of death

12. Underlying cause of death

13. Contributing cause of death

14. Manner of death

15. Signature of physician

16. Signature of registrar

17. Signature of informant

18. Signature of witness

19. Signature of funeral director

20. Signature of coroner

21. Signature of justice of the peace

22. Signature of health officer

23. Signature of state health officer

24. Signature of state health commissioner

25. Signature of state health director

26. Signature of state health administrator

27. Signature of state health supervisor

28. Signature of state health inspector

29. Signature of state health examiner

30. Signature of state health auditor

31. Signature of state health controller

32. Signature of state health treasurer

33. Signature of state health clerk

34. Signature of state health stenographer

35. Signature of state health messenger

36. Signature of state health janitor

37. Signature of state health cook

38. Signature of state health cleaner

39. Signature of state health porter

40. Signature of state health watchman

41. Signature of state health guard

42. Signature of state health patrolman

43. Signature of state health detective

44. Signature of state health investigator

BUREAU V. S.

AUG 16 1955

RECEIVED

7298
CERTIFICATE OF DEATH

07315

Item 9, Film G185 8-26-55 et

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		12/28/53		TOWN Frostburg		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Allegany County Infirmary				Park Avenue			
3. NAME OF DECEASED (Type or Print)				DATE OF DEATH			
(First) Snyder		(Middle)		(Last) Washington		(Month) (Day) (Year) August 13, 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored	Widower	4 - 6 - 1872	82 83 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired - Delivery Man					(Mineral County) Springfield, W. Va.		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Louis Washington				Katherine Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No						Allegany County Infirmary Records	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				Cerebral Hemorrhage			
ANTECEDENT CAUSE(S) DUE TO				Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				Cerebral Arteriosclerosis			
				Senile Deterioration			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 28, 19 53 , to Aug. 13, 19 55 , that I last saw the deceased alive on Aug. 12, 19 55 , and that death occurred at 10:40 P.M. , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
James E. McLean M.D.				49 Green St. 8-13-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8 - 16 - 1955		Frostburg Memorial Park		Frostburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug. 17, 1955		Walter R. Frank M.D.		B. H. Monticourt		23 E. Main Frostburg, Md.	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Race (White, Negro, etc.)

4. Date of birth (Month, Day, Year)

5. Place of birth (City, State, Country)

6. Usual residence (Street, City, State, Country)

7. Date of death (Month, Day, Year)

8. Time of death (Hour, Minute)

9. Cause of death (Immediate cause)

10. Cause of death (Underlying cause)

11. Cause of death (Contributing cause)

12. Signature of physician (Print name)

13. Signature of registrar (Print name)

14. Signature of informant (Print name)

15. Signature of witness (Print name)

16. Signature of witness (Print name)

17. Signature of witness (Print name)

18. Signature of witness (Print name)

19. Signature of witness (Print name)

20. Signature of witness (Print name)

21. Signature of witness (Print name)

22. Signature of witness (Print name)

23. Signature of witness (Print name)

24. Signature of witness (Print name)

25. Signature of witness (Print name)

26. Signature of witness (Print name)

27. Signature of witness (Print name)

28. Signature of witness (Print name)

29. Signature of witness (Print name)

30. Signature of witness (Print name)

31. Signature of witness (Print name)

32. Signature of witness (Print name)

33. Signature of witness (Print name)

34. Signature of witness (Print name)

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Race (White, Negro, etc.)

4. Date of birth (Month, Day, Year)

5. Place of birth (City, State, Country)

6. Usual residence (Street, City, State, Country)

7. Date of death (Month, Day, Year)

8. Time of death (Hour, Minute)

9. Cause of death (Immediate cause)

10. Cause of death (Underlying cause)

11. Cause of death (Contributing cause)

12. Signature of physician (Print name)

13. Signature of registrar (Print name)

14. Signature of informant (Print name)

15. Signature of witness (Print name)

16. Signature of witness (Print name)

17. Signature of witness (Print name)

18. Signature of witness (Print name)

19. Signature of witness (Print name)

20. Signature of witness (Print name)

21. Signature of witness (Print name)

22. Signature of witness (Print name)

23. Signature of witness (Print name)

24. Signature of witness (Print name)

25. Signature of witness (Print name)

26. Signature of witness (Print name)

27. Signature of witness (Print name)

28. Signature of witness (Print name)

29. Signature of witness (Print name)

30. Signature of witness (Print name)

31. Signature of witness (Print name)

32. Signature of witness (Print name)

33. Signature of witness (Print name)

34. Signature of witness (Print name)

BUREAU V. 3

AUG 18 1955

RECEIVED

Free Press, Montreal, 1955

8-10-1955

10-1

RECEIVED
NO. 100
10-1

7293

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Item 8, Film G185 8-12-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND COUNTY ALLEGANY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN CUMBERLAND		LENGTH OF STAY (in this place) 5 DAYS		OR TOWN CUMBERLAND, RURAL		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		STREET ADDRESS #2, WILLIAMS ROAD					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) LENA (Middle) (Last) WEBSTER				(Month) AUGUST 3 (Day) 19 (Year) 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH DECEMBER 17, 1906	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB IMAN				14. MOTHER'S MAIDEN NAME REBECCA SWICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Massive R. Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH July 25, 1955			
ANTECEDENT CAUSE(S) DUE TO (B) Left Hemiplegia							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 30, 1955 , to Aug 3, 1955 , that I last saw the deceased alive on Aug 3, 1955 , and that death occurred at 10:05 A.M. from the causes and on the date stated above.							
SIGNATURE Clayton J. Surratt M.D.				ADDRESS (Street, city, town, state) Cumberland, Md.		DATE SIGNED 8/5/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 6, 1955		NAME OF CEMETERY OR CREMATORY Lahmansville Cemetery		LOCATION (City, town, or county) (State) Lahmansville, West Virginia	
24. REC'D BY REGISTRAR Aug 5, 1955		REGISTRAR'S SIGNATURE Walter R. Brantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J. Blaine Schaeffer		ADDRESS Petersburg, W.V.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

03318

HEALTH STATE DEPARTMENT OF HEALTH-BALTIMORE

CERTIFICATE OF DEATH

COUNTY OF BALTIMORE CITY OF BALTIMORE WARD OF BALTIMORE		DECEASED NAME SEX AGE DATE OF BIRTH PLACE OF BIRTH	
RESIDENCE STREET CITY STATE ZIP		OCCUPATION TRADE INDUSTRY SERVICE	
DATE OF DEATH TIME OF DEATH PLACE OF DEATH		CAUSE OF DEATH IMMEDIATE UNDERLYING	
SIGNATURE OF PHYSICIAN NAME ADDRESS CITY STATE ZIP		SIGNATURE OF REGISTRAR NAME ADDRESS CITY STATE ZIP	
SIGNATURE OF WITNESS NAME ADDRESS CITY STATE ZIP		SIGNATURE OF WITNESS NAME ADDRESS CITY STATE ZIP	

BUREAU V. 3

AUG 8 1955

RECEIVED

7300

CERTIFICATE OF DEATH

07317

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>515 Hill Top Drive</u>		STREET ADDRESS (If rural give location) <u>515 Hill Top Drive</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>ALICE</u> (Middle) <u>JEANETTE</u> (Last) <u>WHEELER</u>		(Month) <u>Aug.</u> (Day) <u>31</u> (Year) <u>19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 3, 1906</u>
		9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garment Fac.</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>JOHN TIPTON</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA BARNHART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>294-22-9278</u>	
		17. INFORMANT & ADDRESS <u>Jay Wheeler, 515 Hill Top Drive.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
IMMEDIATE CAUSE (A) <u>171X Carcinoma of Cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Mar. 1954</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatous</u>			<u>Mar. 1955</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 1, 1955</u> to <u>Aug. 31, 1955</u> , that I last saw the deceased alive on <u>Aug. 1, 1955</u> , and that death occurred at <u>9/1/55</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Clay E. Luerdt</u>		ADDRESS (Street, city, town, state) <u>Cumberland - Md 9/1/55</u>	
DATE <u>Sept. 3, 1955</u>		M.D. <u>Winters R. Frank, M.D.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 3, 1955</u>	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cemetery</u>	
25. FUNERAL DIRECTOR'S SIGNATURE		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
26. ADDRESS			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Outside of City Limits

7321

CERTIFICATE OF DEATH

07318

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Cumberland, Route 6</u>				OR TOWN <u>Route 6, Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>350 Nat'l Highway</u>				STREET ADDRESS (If rural give location) <u>350 Nat'l Highway</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u>		(Middle) <u>HENRY</u>		(Last) <u>WIEGAND</u>		(Month) (Day) (Year) <u>August 6, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 23, 1879</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l Biscuit</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wiegand</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-6895</u>		17. INFORMANT & ADDRESS <u>Mrs. Wm. Henry Wiegand, Rt. 6, Cumberland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>442X</u> IMMEDIATE CAUSE (A) <u>Cardio Vascular</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Renal Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-20-55</u> to <u>8-6-55</u> that I last saw the deceased alive on <u>7-30-55</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. F. Williams</u>				ADDRESS (Street, city, town, state) <u>Cumberland</u>		DATE SIGNED <u>8-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Frank M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) _____
 TOWN Cumberland LENGTH OF STAY (in this place) 3 hrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town) _____
 OR TOWN Cumberland
 STREET ADDRESS (If rural, give location) 7 Browning St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JohnPerryWillard

4. DATE OF DEATH

(Month)

(Day)

(Year)

Aug. 1919 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

malewhitemarriedMarch 30-189461

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

MachinistB&O.R.Ry.Cumberland, Md.U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Oscar A. WillardMary C. Meders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

420.1
Immediate cause

(a) DUE TO

Coronary sclerosis, left
Myocardial infarction, leftAntecedent cause(s)Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Mural thrombous also had (left)

(c)

Cerebral edema, marked.?about5 daysabout4 hrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D.

M. D.

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

Aug. 19-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialAug. 22, 1955Allestree CemeteryCumberland, Maryland

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug. 20, 1955Walter K. Hunt, M.D.James T. Scarpelli, ""

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 24 1957

BUREAU V. S.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G185 8-19-55 ems

7312

CERTIFICATE OF DEATH

07320

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>3 Hr. 10 Min</u>		CITY OR TOWN <u>02 Cumberland</u>		STREET ADDRESS (If rural give location) <u>600 Elwood St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>462 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>600 Elwood St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>Phillip</u> (Last) <u>Wilson</u>				(Month) <u>8/</u> (Day) <u>3</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/17/96</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mailcarrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Service</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Agustus Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Sophia H einrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>214 05 9746</u>		17. INFORMANT & ADDRESS <u>Patient's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
340.1 IMMEDIATE CAUSE (A) <u>Meningitis, Pneumococcus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-2-</u> , 19 <u>55</u> , to <u>8-3-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-3-</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L. P. Harris</u>				ADDRESS (Street, city, town, state) <u>576 W. 11th St. Cumberland Md 8-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Aug. 5, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

Page One of Two

A. NAME (PRINT OR TYPE FULL NAME)

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

UNDERLYING CAUSE

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BUREAU V. S.

AUG 8 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07321

7322

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) Lonaconing		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church ***** Street				STREET ADDRESS (If rural give location) Church Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JOHN		(Middle)		(Last) WORGAN		(Month) (Day) (Year) Aug, 4th. 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 15. 1888	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Textile (Silk Mill)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hubert Worgan				14. MOTHER'S MAIDEN NAME Miriam Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 216-07-2713		17. INFORMANT & ADDRESS Mrs. Ellis Whitefield, (SISTER)			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION Lonaconing, MD.			
523.3 IMMEDIATE CAUSE (A) Congestive Heart failure				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
ANTECEDENT CAUSE(S) DUE TO (B) Cor Pulmonale				1 year			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) Pneumonia				10-15 yrs.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1952 , to Aug 1955 , that I last saw the deceased alive on Aug 55 , and that death occurred at 12:07 A.M. from the causes and on the date stated above.							
SIGNATURE George Richards				DATE SIGNED 8-4-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF Aug, 6. 1955		NAME OF CEMETERY OR CREMATORY Old Coney Cemetery	
				LOCATION (City, town, or county) Lonaconing, MD.		(State)	
24. REG'D BY REGISTRAR DATE Aug 6 1955		REGISTRAR'S SIGNATURE Janette M Boal		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. STREET

9. CITY

10. COUNTY

11. STATE

12. DATE OF DEATH

13. TIME OF DEATH

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF MINISTER

18. SIGNATURE OF JUDGE

19. SIGNATURE OF CLERK

BUREAU V. 2

AUG 15 1935

RECEIVED

THE BUREAU OF VITAL RECORDS, DEPARTMENT OF HEALTH, STATE OF NEW YORK, ALBANY, N. Y.

1

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07322

7303 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale,</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Stella</u>		(Middle) <u>B.</u>		(Last) <u>Yeider</u>		(Month) (Day) (Year) <u>8-22-55</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-27-98</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Corrigan</u>				14. MOTHER'S MAIDEN NAME <u>Fouch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A) <u>Carcinoma Colon</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 21, 1955</u> , to <u>August 22, 1955</u> , that I last saw the deceased alive on <u>August 22, 1955</u> , and that death occurred at <u>41 Greenfield</u> M, from the causes and on the date stated above. SIGNATURE <u>D. M. Schindler</u> M.D. DATE SIGNED <u>MD 8/24/55</u> ADDRESS (Street) city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug, 26 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Belvedere Cemetery</u>		LOCATION (City, town, or county) (State) <u>Midland, MD.</u>	
24. REC'D BY REGISTRAR <u>Aug. 25, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		ADDRESS <u>Lonaconing, MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

07352

Page 1 of 1

1. DATE OF DEATH (Month, Day, Year)

2. PLACE OF DEATH (City, State, Country)

3. TIME OF DEATH (Hour, Minute)

4. CAUSE OF DEATH (Disease, Injury, Poison, etc.)

5. MANNER OF DEATH (Natural, Accidental, Suicidal, Homicidal, etc.)

6. AGENT OF DEATH (Infectious Agent, Trauma, etc.)

7. SEX (Male, Female)

8. AGE (Years, Months, Days)

9. RACE (White, Negro, Other)

10. OCCUPATION (Profession, Trade, etc.)

11. EDUCATION (Grade, Degree, etc.)

12. MARITAL STATUS (Single, Married, Widowed, Divorced)

13. PLACE OF BIRTH (City, State, Country)

14. DATE OF BIRTH (Month, Day, Year)

15. SIGNATURE OF DECEASED (If known)

16. SIGNATURE OF WITNESSES (Two or more)

17. SIGNATURE OF PHYSICIAN (If known)

18. SIGNATURE OF CORONER (If known)

19. SIGNATURE OF REGISTRAR (If known)

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